

AMENDED IN SENATE JUNE 20, 2013

AMENDED IN ASSEMBLY MAY 2, 2013

AMENDED IN ASSEMBLY APRIL 16, 2013

AMENDED IN ASSEMBLY MARCH 21, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL

No. 1180

Introduced by Assembly Member Pan

February 22, 2013

An act to amend Sections 1363.06, 1363.07, 1366.3, 1366.35, 1373.6, 1373.621, *1373.622*, 1389.5, 1399.805, 1399.810, 1399.811, and 1399.815 of, and to add Section 1373.620 to, the Health and Safety Code, and to amend Sections 10116.5, 10119.1, 10127.14, *10127.16*, 10127.18, 10785, 10901.3, 10901.8, 10901.9, 10902.3, 12672, and 12682.1 of, to add Section 12682.2 to, and to repeal Section 10902.6 of, the Insurance Code, relating to health care coverage, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 1180, as amended, Pan. Health care coverage: federally eligible defined individuals: conversion or continuation of coverage.

(1) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Insurance Commissioner. Existing law requires a health care service plan or a health insurer offering individual plan contracts or individual insurance policies to fairly and affirmatively

offer, market, and sell certain individual contracts and policies to all federally eligible defined individuals, as defined, in each service area in which the plan or insurer provides or arranges for the provision of health care services. Existing law prohibits the premium for those policies and contracts from exceeding the premium paid by a subscriber of the California Major Risk Medical Insurance Program who is of the same age and resides in the same geographic region as the federally eligible defined individual, as specified.

This bill would make these provisions of law applicable only to individual grandfathered health plans, as defined, previously issued to federally eligible defined individuals, unless and until specified provisions of the federal Patient Protection and Affordable Care Act (PPACA) are amended or repealed, as specified. The bill would also require a health care service plan or an insurer, at least 60 days prior to the plan or policy renewal date, to issue prescribed notifications to a person who is enrolled in an individual health benefit plan or individual health insurance policy that is not a grandfathered health plan. *The bill would also impose the notification requirement for individuals who are covered under the California Major Risk Medical Insurance Program.* Because a willful violation of this requirement by a health care service plan would be a crime, the bill would impose a state-mandated local program.

(2) Existing law establishes a formula establishing the upper limit for premium charges for health care plans and health insurance. Existing law authorizes the plan and insurer to adjust the premium based on family size, as specified.

This bill would, instead of the current formula, limit the premium charged for coverage provided in 2014 to the rate charged in 2013 multiplied by 1.09 and would limit the rate of growth thereafter, as specified.

~~(2)~~

(3) Existing law requires a health care service plan or health insurer to offer continuation or conversion of individual or group coverage for a specified period of time and under certain circumstances.

The bill would make those provisions inoperative, unless and until specified provisions of PPACA are amended or repealed, as specified, and would make conforming changes.

~~(3)~~

(4) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: $\frac{2}{3}$. Appropriation: no. Fiscal committee: yes.

State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 1363.06 of the Health and Safety Code
2 is amended to read:

3 1363.06. (a) The Department of Managed Health Care and the
4 Department of Insurance shall compile information as required by
5 this section and Section 10127.14 of the Insurance Code into two
6 comparative benefit matrices. The first matrix shall compare benefit
7 packages offered pursuant to Section 1373.62 and Section 10127.15
8 of the Insurance Code. The second matrix shall compare benefit
9 packages offered pursuant to Sections 1366.35, 1373.6, and
10 1399.804 and Sections 10785, 10901.2, and 12682.1 of the
11 Insurance Code.

12 (b) The comparative benefit matrix shall include:

13 (1) Benefit information submitted by health care service plans
14 pursuant to subdivision (d) and by health insurers pursuant to
15 Section 10127.14 of the Insurance Code.

16 (2) The following statements in at least 12-point type at the top
17 of the matrix:

18 (A) "This benefit summary is intended to help you compare
19 coverage and benefits and is a summary only. For a more detailed
20 description of coverage, benefits, and limitations, please contact
21 the health care service plan or health insurer."

22 (B) "The comparative benefit summary is updated annually, or
23 more often if necessary to be accurate."

24 (C) "The most current version of this comparative benefit
25 summary is available on (address of the plan's or insurer's *Internet*
26 *Web* site)."

27 This subparagraph applies only to those plans or insurers that
28 maintain an Internet Web site.

(3) The telephone number or numbers that may be used by an applicant to contact either the department or the Department of Insurance, as appropriate, for further assistance.

(c) The Department of Managed Health Care and the Department of Insurance shall jointly prepare two standardized templates for use by health care service plans and health insurers in submitting the information required pursuant to subdivision (d) and subdivision (d) of Section 10127.14 of the Insurance Code. The templates shall be exempt from the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(d) Health care service plans, except specialized health care service plans, shall submit the following to the department by January 31, 2003, and annually thereafter:

(1) A summary explanation of the following for each product described in subdivision (a).

(A) Eligibility requirements.

(B) The full premium cost of each benefit package in the service area in which the individual and eligible dependents work or reside.

(C) When and under what circumstances benefits cease.

(D) The terms under which coverage may be renewed.

(E) Other coverage that may be available if benefits under the described benefit package cease.

(F) The circumstances under which choice in the selection of physicians and providers is permitted.

(G) Lifetime and annual maximums.

(H) Deductibles.

(2) A summary explanation of coverage for the following, together with the corresponding copayments and limitations, for each product described in subdivision (a):

(A) Professional services.

(B) Outpatient services.

(C) Hospitalization services.

(D) Emergency health coverage.

(E) Ambulance services.

(F) Prescription drug coverage.

(G) Durable medical equipment.

(H) Mental health services.

(I) Residential treatment.

(J) Chemical dependency services.

1 (K) Home health services.

2 (L) Custodial care and skilled nursing facilities.

3 (3) The telephone number or numbers that may be used by an
4 applicant to access a health care service plan customer service
5 representative and to request additional information about the plan
6 contract.

7 (4) Any other information specified by the department in the
8 template.

9 (e) Each health care service plan shall provide the department
10 with updates to the information required by subdivision (d) at least
11 annually, or more often if necessary to maintain the accuracy of
12 the information.

13 (f) The department and the Department of Insurance shall make
14 the comparative benefit matrices available on their respective
15 Internet Web sites and to the health care service plans and health
16 insurers for dissemination as required by Section 1373.6 and
17 Section 12682.1 of the Insurance Code, after confirming the
18 accuracy of the description of the matrices with the health care
19 service plans and health insurers.

20 (g) As used in this section and Section 1363.07, “benefit matrix”
21 shall have the same meaning as benefit summary.

22 (h) (1) This section shall be inoperative on January 1, 2014.

23 (2) If Section 5000A of the Internal Revenue Code, as added
24 by Section 1501 of PPACA, is repealed or amended to no longer
25 apply to the individual market, as defined in Section 2791 of the
26 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this
27 section shall become operative on the date of that repeal or
28 amendment.

29 (3) For purposes of this subdivision, “PPACA” means the federal
30 Patient Protection and Affordable Care Act (Public Law 111-148),
31 as amended by the federal Health Care Education and
32 Reconciliation Act of 2010 (Public Law 111-152), and any rules,
33 regulations, or guidance issued pursuant to that law.

34 SEC. 2. Section 1363.07 of the Health and Safety Code is
35 amended to read:

36 1363.07. (a) Each health care service plan shall send copies
37 of the comparative benefit matrix prepared pursuant to Section
38 1363.06 on an annual basis, or more frequently as the matrix is
39 updated by the department and the Department of Insurance, to

1 solicitors and solicitor firms and employers with whom the plan
2 contracts.

3 (b) Each health care service plan shall require its representatives
4 and solicitors and soliciting firms with which it contracts, to
5 provide a copy of the comparative benefit matrix to individuals
6 when presenting any benefit package for examination or sale.

7 (c) Each health care service plan that maintains an Internet Web
8 site shall make a downloadable copy of the comparative benefit
9 matrix described in Section 1363.06 available through a link on
10 its site to the Internet Web sites of the department and the
11 Department of Insurance.

12 (d) (1) This section shall be inoperative on January 1, 2014.

13 (2) If Section 5000A of the Internal Revenue Code, as added
14 by Section 1501 of PPACA, is repealed or amended to no longer
15 apply to the individual market, as defined in Section 2791 of the
16 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this
17 section shall become operative on the date of that repeal or
18 amendment.

19 (3) For purposes of this subdivision, “PPACA” means the federal
20 Patient Protection and Affordable Care Act (Public Law 111-148),
21 as amended by the federal Health Care Education and
22 Reconciliation Act of 2010 (Public Law 111-152), and any rules,
23 regulations, or guidance issued pursuant to that law.

24 SEC. 3. Section 1366.3 of the Health and Safety Code is
25 amended to read:

26 1366.3. (a) On and after January 1, 2005, a health care service
27 plan issuing individual plan contracts that ceases to offer individual
28 coverage in this state shall offer coverage to the subscribers who
29 had been covered by those contracts at the time of withdrawal
30 under the same terms and conditions as provided in paragraph (3)
31 of subdivision (a), paragraphs (2) to (4), inclusive, of subdivision
32 (b), subdivisions (c) to (e), inclusive, and subdivision (h) of Section
33 1373.6.

34 (b) A health care service plan that ceases to offer individual
35 coverage in a service area shall offer the coverage required by
36 subdivision (a) to subscribers who had been covered by those
37 contracts at the time of withdrawal, if the plan continues to offer
38 group coverage in that service area. This subdivision shall not
39 apply to coverage provided pursuant to a preferred provider
40 organization.

1 (c) The department may adopt regulations to implement this
2 section.

3 (d) This section shall not apply when a plan participating in
4 Medi-Cal, Healthy Families, Access for Infants and Mothers, or
5 any other contract between the plan and a government entity no
6 longer contracts with the government entity to provide health
7 coverage in the state, or a specified area of the state, nor shall this
8 section apply when a plan ceases entirely to market, offer, and
9 issue any and all forms of coverage in any part of this state after
10 the effective date of this section.

11 (e) (1) On and after January 1, 2014, and except as provided
12 in paragraph (2), the reference to Section 1373.6 in subdivision
13 (a) shall not apply to any health plan contracts.

14 (2) If Section 5000A of the Internal Revenue Code, as added
15 by Section 1501 of the federal Patient Protection and Affordable
16 Care Act (Public Law 111-148), as amended by the federal Health
17 Care and Education Reconciliation Act of 2010 (Public Law
18 111-152), is repealed or amended to no longer apply to the
19 individual market, as defined in Section 2791 of the federal Public
20 Health Service Act (42 U.S.C. Section 300gg-91), paragraph (1)
21 shall become inoperative on the date of that repeal or amendment.

22 SEC. 4. Section 1366.35 of the Health and Safety Code is
23 amended to read:

24 1366.35. (a) A health care service plan providing coverage
25 for hospital, medical, or surgical benefits under an individual health
26 care service plan contract may not, with respect to a federally
27 eligible defined individual desiring to enroll in individual health
28 insurance coverage, decline to offer coverage to, or deny enrollment
29 of, the individual or impose any preexisting condition exclusion
30 with respect to the coverage.

31 (b) For purposes of this section, “federally eligible defined
32 individual” means an individual who, as of the date on which the
33 individual seeks coverage under this section, meets all of the
34 following conditions:

35 (1) Has had 18 or more months of creditable coverage, and
36 whose most recent prior creditable coverage was under a group
37 health plan, a federal governmental plan maintained for federal
38 employees, or a governmental plan or church plan as defined in
39 the federal Employee Retirement Income Security Act of 1974
40 (29 U.S.C. Sec. 1002).

1 (2) Is not eligible for coverage under a group health plan,
2 Medicare, or Medi-Cal, and does not have other health insurance
3 coverage.

4 (3) Was not terminated from his or her most recent creditable
5 coverage due to nonpayment of premiums or fraud.

6 (4) If offered continuation coverage under COBRA or
7 Cal-COBRA, has elected and exhausted that coverage.

8 (c) Every health care service plan shall comply with applicable
9 federal statutes and regulations regarding the provision of coverage
10 to federally eligible defined individuals, including any relevant
11 application periods.

12 (d) A health care service plan shall offer the following health
13 benefit plan contracts under this section that are designed for, made
14 generally available to, are actively marketed to, and enroll,
15 individuals: (1) either the two most popular products as defined
16 in Section 300gg-41(c)(2) of Title 42 of the United States Code
17 and Section 148.120(c)(2) of Title 45 of the Code of Federal
18 Regulations or (2) the two most representative products as defined
19 in Section 300gg-41(c)(3) of the United States Code and Section
20 148.120(c)(3) of Title 45 of the Code of Federal Regulations, as
21 determined by the plan in compliance with federal law. A health
22 care service plan that offers only one health benefit plan contract
23 to individuals, excluding health benefit plans offered to Medi-Cal
24 or Medicare beneficiaries, shall be deemed to be in compliance
25 with this article if it offers that health benefit plan contract to
26 federally eligible defined individuals in a manner consistent with
27 this article.

28 (e) (1) In the case of a health care service plan that offers health
29 insurance coverage in the individual market through a network
30 plan, the plan may do both of the following:

31 (A) Limit the individuals who may be enrolled under that
32 coverage to those who live, reside, or work within the service area
33 for the network plan.

34 (B) Within the service area of the plan, deny coverage to
35 individuals if the plan has demonstrated to the director that the
36 plan will not have the capacity to deliver services adequately to
37 additional individual enrollees because of its obligations to existing
38 group contractholders and enrollees and individual enrollees, and
39 that the plan is applying this paragraph uniformly to individuals
40 without regard to any health status related factor of the individuals

1 and without regard to whether the individuals are federally eligible
2 defined individuals.

3 (2) A health care service plan, upon denying health insurance
4 coverage in any service area in accordance with subparagraph (B)
5 of paragraph (1), may not offer coverage in the individual market
6 within that service area for a period of 180 days after the coverage
7 is denied.

8 (f) (1) A health care service plan may deny health insurance
9 coverage in the individual market to a federally eligible defined
10 individual if the plan has demonstrated to the director both of the
11 following:

12 (A) The plan does not have the financial reserves necessary to
13 underwrite additional coverage.

14 (B) The plan is applying this subdivision uniformly to all
15 individuals in the individual market and without regard to any
16 health status-related factor of the individuals and without regard
17 to whether the individuals are federally eligible *defined* individuals.

18 (2) A health care service plan, upon denying individual health
19 insurance coverage in any service area in accordance with
20 paragraph (1), may not offer that coverage in the individual market
21 within that service area for a period of 180 days after the date the
22 coverage is denied or until the issuer has demonstrated to the
23 director that the plan has sufficient financial reserves to underwrite
24 additional coverage, whichever is later.

25 (g) The requirement pursuant to federal law to furnish a
26 certificate of creditable coverage shall apply to health insurance
27 coverage offered by a health care service plan in the individual
28 market in the same manner as it applies to a health care service
29 plan in connection with a group health benefit plan.

30 (h) A health care service plan shall compensate a life agent or
31 fire and casualty broker-agent whose activities result in the
32 enrollment of federally eligible defined individuals in the same
33 manner and consistent with the renewal commission amounts as
34 the plan compensates life agents or fire and casualty broker-agents
35 for other enrollees who are not federally eligible defined
36 individuals and who are purchasing the same individual health
37 benefit plan contract.

38 (i) Every health care service plan shall disclose as part of its
39 COBRA or Cal-COBRA disclosure and enrollment documents,
40 an explanation of the availability of guaranteed access to coverage

1 under the Health Insurance Portability and Accountability Act of
2 1996, including the necessity to enroll in and exhaust COBRA or
3 Cal-COBRA benefits in order to become a federally eligible
4 defined individual.

5 (j) No health care service plan may request documentation as
6 to whether or not a person is a federally eligible defined individual
7 other than is permitted under applicable federal law or regulations.

8 (k) This section shall not apply to coverage defined as excepted
9 benefits pursuant to Section 300gg(c) of Title 42 of the United
10 States Code.

11 (l) This section shall apply to health care service plan contracts
12 offered, delivered, amended, or renewed on or after January 1,
13 2001.

14 (m) (1) This section shall be inoperative on January 1, 2014.

15 (2) If Section 5000A of the Internal Revenue Code, as added
16 by Section 1501 of PPACA, is repealed or amended to no longer
17 apply to the individual market, as defined in Section 2791 of the
18 federal Public Health Service Act (42 U.S.C. Section 300gg-91),
19 this section shall become operative on the date of that repeal or
20 amendment.

21 (3) For purposes of this subdivision, “PPACA” means the federal
22 Patient Protection and Affordable Care Act (Public Law 111-148),
23 as amended by the federal Health Care Education and
24 Reconciliation Act of 2010 (Public Law 111-152), and any rules,
25 regulations, or guidance issued pursuant to that law.

26 SEC. 5. Section 1373.6 of the Health and Safety Code is
27 amended to read:

28 1373.6. This section does not apply to a specialized health care
29 service plan contract or to a plan contract that primarily or solely
30 supplements Medicare. The director may adopt rules consistent
31 with federal law to govern the discontinuance and replacement of
32 plan contracts that primarily or solely supplement Medicare.

33 (a) (1) Every group contract entered into, amended, or renewed
34 on or after September 1, 2003, that provides hospital, medical, or
35 surgical expense benefits for employees or members shall provide
36 that an employee or member whose coverage under the group
37 contract has been terminated by the employer shall be entitled to
38 convert to nongroup membership, without evidence of insurability,
39 subject to the terms and conditions of this section.

1 (2) If the health care service plan provides coverage under an
2 individual health care service plan contract, other than conversion
3 coverage under this section, it shall offer one of the two plans that
4 it is required to offer to a federally eligible defined individual
5 pursuant to Section 1366.35. The plan shall provide this coverage
6 at the same rate established under Section 1399.805 for a federally
7 eligible defined individual. A health care service plan that is
8 federally qualified under the federal Health Maintenance
9 Organization Act (42 U.S.C. Sec. 300e et seq.) may charge a rate
10 for the coverage that is consistent with the provisions of that act.

11 (3) If the health care service plan does not provide coverage
12 under an individual health care service plan contract, it shall offer
13 a health benefit plan contract that is the same as a health benefit
14 contract offered to a federally eligible defined individual pursuant
15 to Section 1366.35. The health care service plan may offer either
16 the most popular health maintenance organization model plan or
17 the most popular preferred provider organization plan, each of
18 which has the greatest number of enrolled individuals for its type
19 of plan as of January 1 of the prior year, as reported by plans that
20 provide coverage under an individual health care service plan
21 contract to the department or the Department of Insurance by
22 January 31, 2003, and annually thereafter. A health care service
23 plan subject to this paragraph shall provide this coverage with the
24 same cost-sharing terms and at the same premium as a health care
25 service plan providing coverage to that individual under an
26 individual health care service plan contract pursuant to Section
27 1399.805. The health care service plan shall file the health benefit
28 plan it will offer, including the premium it will charge and the
29 cost-sharing terms of the plan, with the Department of Managed
30 Health Care.

31 (b) A conversion contract shall not be required to be made
32 available to an employee or member if termination of his or her
33 coverage under the group contract occurred for any of the following
34 reasons:

35 (1) The group contract terminated or an employer's participation
36 terminated and the group contract is replaced by similar coverage
37 under another group contract within 15 days of the date of
38 termination of the group coverage or the subscriber's participation.

39 (2) The employee or member failed to pay amounts due the
40 health care service plan.

1 (3) The employee or member was terminated by the health care
2 service plan from the plan for good cause.

3 (4) The employee or member knowingly furnished incorrect
4 information or otherwise improperly obtained the benefits of the
5 plan.

6 (5) The employer's hospital, medical, or surgical expense benefit
7 program is self-insured.

8 (c) A conversion contract is not required to be issued to any
9 person if any of the following facts are present:

10 (1) The person is covered by or is eligible for benefits under
11 Title XVIII of the United States Social Security Act.

12 (2) The person is covered by or is eligible for hospital, medical,
13 or surgical benefits under any arrangement of coverage for
14 individuals in a group, whether insured or self-insured.

15 (3) The person is covered for similar benefits by an individual
16 policy or contract.

17 (4) The person has not been continuously covered during the
18 three-month period immediately preceding that person's
19 termination of coverage.

20 (d) Benefits of a conversion contract shall meet the requirements
21 for benefits under this chapter.

22 (e) Unless waived in writing by the plan, written application
23 and first premium payment for the conversion contract shall be
24 made not later than 63 days after termination from the group. A
25 conversion contract shall be issued by the plan which shall be
26 effective on the day following the termination of coverage under
27 the group contract if the written application and the first premium
28 payment for the conversion contract are made to the plan not later
29 than 63 days after the termination of coverage, unless these
30 requirements are waived in writing by the plan.

31 (f) The conversion contract shall cover the employee or member
32 and his or her dependents who were covered under the group
33 contract on the date of their termination from the group.

34 (g) A notification of the availability of the conversion coverage
35 shall be included in each evidence of coverage. However, it shall
36 be the sole responsibility of the employer to notify its employees
37 of the availability, terms, and conditions of the conversion coverage
38 which responsibility shall be satisfied by notification within 15
39 days of termination of group coverage. Group coverage shall not
40 be deemed terminated until the expiration of any continuation of

1 the group coverage. For purposes of this subdivision, the employer
2 shall not be deemed the agent of the plan for purposes of
3 notification of the availability, terms, and conditions of conversion
4 coverage.

5 (h) As used in this section, “hospital, medical, or surgical
6 benefits under state or federal law” do not include benefits under
7 Chapter 7 (commencing with Section 14000) or Chapter 8
8 (commencing with Section 14200) of Part 3 of Division 9 of the
9 Welfare and Institutions Code, or Title XIX of the United States
10 Social Security Act.

11 (i) Every group contract entered into, amended, or renewed
12 before September 1, 2003, shall be subject to the provisions of this
13 section as it read prior to its amendment by Assembly Bill 1401
14 of the 2001–02 Regular Session.

15 (j) (1) On and after January 1, 2014, and except as provided in
16 paragraph (2), this section shall apply only to individual
17 grandfathered health plan contracts previously issued pursuant to
18 this section to federally eligible defined individuals.

19 (2) If Section 5000A of the Internal Revenue Code, as added
20 by Section 1501 of PPACA, is repealed or amended to no longer
21 apply to the individual market, as defined in Section 2791 of the
22 federal Public Health Service Act (42 U.S.C. Section 300gg-91),
23 paragraph (1) shall become inoperative on the date of that repeal
24 or amendment.

25 (3) For purposes of this subdivision, the following definitions
26 apply:

27 (A) “Grandfathered health plan” has the same meaning as that
28 term is defined in Section 1251 of the PPACA.

29 (B) “PPACA” means the federal Patient Protection and
30 Affordable Care Act (Public Law 111-148), as amended by the
31 federal Health Care Education and Reconciliation Act of 2010
32 (Public Law 111-152), and any rules, regulations, or guidance
33 issued pursuant to that law.

34 SEC. 6. Section 1373.620 is added to the Health and Safety
35 Code, to read:

36 1373.620. (a) (1) At least 60 days prior to the plan renewal
37 date, a health care service plan that does not otherwise issue
38 individual health care service plan contracts shall issue the notice
39 described in paragraph (2) to any subscriber enrolled in an

1 individual health benefit plan contract issued pursuant to Section
2 1373.6 that is not a grandfathered health plan.

3 (2) The notice shall be in at least 12-point type and shall include
4 all of the following:

5 (A) Notice that, as of the renewal date, the individual plan
6 contract will not be renewed.

7 (B) The availability of individual health coverage through
8 Covered California, including at least all of the following:

9 (i) That, beginning on January 1, 2014, individuals seeking
10 coverage may not be denied coverage based on health status.

11 (ii) That the premium rates for coverage offered by a health care
12 service plan or a health insurer cannot be based on an individual's
13 health status.

14 (iii) That individuals obtaining coverage through Covered
15 California may, depending upon income, be eligible for premium
16 subsidies and cost-sharing subsidies.

17 (iv) That individuals seeking coverage must obtain this coverage
18 during an open or special enrollment period, and a description of
19 the open and special enrollment periods that may apply.

20 (b) (1) At least 60 days prior to the plan renewal date, a health
21 care service plan that issues individual health care service plan
22 contracts shall issue the notice described in paragraph (2) to a
23 subscriber enrolled in an individual health benefit plan contract
24 issued pursuant to Section 1366.35 or 1373.6 that is not a
25 grandfathered health plan.

26 (2) The notice shall be in at least 12-point type and shall include
27 all of the following:

28 (A) Notice that, as of the renewal date, the individual plan
29 contract will not be renewed.

30 (B) Information regarding the individual health plan contract
31 that the health plan will issue as of January 1, 2014, which the
32 health plan has reasonably concluded is the most comparable to
33 the individual's current plan. The notice shall include information
34 on premiums for the possible replacement plan and instructions
35 that the individual can continue their coverage by paying the
36 premium stated by the due date.

37 (C) Notice of the availability of other individual health coverage
38 through Covered California, including at least all of the following:

39 (i) That, beginning on January 1, 2014, individuals seeking
40 coverage may not be denied coverage based on health status.

1 (ii) That the premium rates for coverage offered by a health care
2 service plan or a health insurer cannot be based on an individual's
3 health status.

4 (iii) That individuals obtaining coverage through Covered
5 California may, depending upon income, be eligible for premium
6 subsidies and cost-sharing subsidies.

7 (iv) That individuals seeking coverage must obtain this coverage
8 during an open or special enrollment period, and a description of
9 the open and special enrollment periods that may apply.

10 (c) No later than September 1, 2013, the department, in
11 consultation with the Department of Insurance, shall adopt uniform
12 model notices that health plans shall use to comply with
13 subdivisions (a) and (b) *and Sections 1366.56 and 1373.622*. Use
14 of the model notices shall not require prior approval by the
15 department. The model notices adopted by the department for
16 purposes of this section shall not be subject to the Administrative
17 Procedure Act (Chapter 3.5 (commencing with Section 11340) of
18 Part 1 of Division 3 of Title 2 of the Government Code). *The*
19 *director may modify the wording of these model notices specifically*
20 *for the purposes of clarity, readability, and accuracy.*

21 (d) For purposes of this section, the following definitions shall
22 apply:

23 (1) "Covered California" means the California Health Benefit
24 Exchange established pursuant to Section 100500 of the
25 Government Code.

26 (2) "Grandfathered health plan" has the same meaning as that
27 term is defined in Section 1251 of PPACA.

28 (3) "PPACA" means the federal Patient Protection and
29 Affordable Care Act (Public Law 111-148), as amended by the
30 federal Health Care and Education Reconciliation Act of 2010
31 (Public Law 111-152), and any rules, regulations, or guidance
32 issued pursuant to that law.

33 SEC. 7. Section 1373.621 of the Health and Safety Code is
34 amended to read:

35 1373.621. (a) Except for a specialized health care service plan,
36 every health care service plan contract that is issued, amended,
37 delivered, or renewed in this state on or after January 1, 1999, that
38 provides hospital, medical, or surgical expense coverage under an
39 employer-sponsored group plan for an employer subject to
40 COBRA, as defined in subdivision (e), or an employer group for

1 which the plan is required to offer Cal-COBRA coverage, as
2 defined in subdivision (f), including a carrier providing replacement
3 coverage under Section 1399.63, shall further offer the former
4 employee the opportunity to continue benefits as required under
5 subdivision (b), and shall further offer the former spouse of an
6 employee or former employee the opportunity to continue benefits
7 as required under subdivision (c).

8 (b) (1) In the event a former employee who worked for the
9 employer for at least five years prior to the date of termination of
10 employment and who is 60 years of age or older on the date
11 employment ends is entitled to and so elects to continue benefits
12 under COBRA or Cal-COBRA for himself or herself and for any
13 spouse, the employee or spouse may further continue benefits
14 beyond the date coverage under COBRA or Cal-COBRA ends, as
15 set forth in paragraph (2). Except as otherwise specified,
16 continuation coverage shall be under the same benefit terms and
17 conditions as if the continuation coverage under COBRA or
18 Cal-COBRA had remained in force. For the employee or spouse,
19 continuation coverage following the end of COBRA or
20 Cal-COBRA is subject to payment of premiums to the health care
21 service plan. Individuals ineligible for COBRA or Cal-COBRA,
22 or who are eligible but have not elected or exhausted continuation
23 coverage under federal COBRA or Cal-COBRA, are not entitled
24 to continuation coverage under this section. Premiums for
25 continuation coverage under this section shall be billed by, and
26 remitted to, the health care service plan in accordance with
27 subdivision (d). Failure to pay the requisite premiums may result
28 in termination of the continuation coverage in accordance with the
29 applicable provisions in the plan's group subscriber agreement
30 with the former employer.

31 (2) The employer shall notify the former employee or spouse
32 or both, or the former spouse of the employee or former employee,
33 of the availability of the continuation benefits under this section
34 in accordance with Section 2800.2 of the Labor Code. To continue
35 health care coverage pursuant to this section, the individual shall
36 elect to do so by notifying the plan in writing within 30 calendar
37 days prior to the date continuation coverage under COBRA or
38 Cal-COBRA is scheduled to end. Every health care service plan
39 and specialized health care service plan shall provide to the
40 employer replacing a health care service plan contract issued by

1 the plan, or to the employer's agent or broker representative, within
2 15 days of any written request, information in possession of the
3 plan reasonably required to administer the requirements of Section
4 2800.2 of the Labor Code.

5 (3) The continuation coverage shall end automatically on the
6 earlier of (A) the date the individual reaches age 65, (B) the date
7 the individual is covered under any group health plan not
8 maintained by the employer or any other health plan, regardless
9 of whether that coverage is less valuable, (C) the date the individual
10 becomes entitled to Medicare under Title XVIII of the Social
11 Security Act, (D) for a spouse, five years from the date on which
12 continuation coverage under COBRA or Cal-COBRA was
13 scheduled to end for the spouse, or (E) the date on which the
14 employer terminates its group subscriber agreement with the health
15 care service plan and ceases to provide coverage for any active
16 employees through that plan, in which case the health care service
17 plan shall notify the former employee or spouse or both of the right
18 to a conversion plan in accordance with Section 1373.6.

19 (c) (1) If a former spouse of an employee or former employee
20 was covered as a qualified beneficiary under COBRA or
21 Cal-COBRA, the former spouse may further continue benefits
22 beyond the date coverage under COBRA or Cal-COBRA ends, as
23 set forth in paragraph (2) of subdivision (b). Except as otherwise
24 specified in this section, continuation coverage shall be under the
25 same benefit terms and conditions as if the continuation coverage
26 under COBRA or Cal-COBRA had remained in force. Continuation
27 coverage following the end of COBRA or Cal-COBRA is subject
28 to payment of premiums to the health care service plan. Premiums
29 for continuation coverage under this section shall be billed by, and
30 remitted to, the health care service plan in accordance with
31 subdivision (d). Failure to pay the requisite premiums may result
32 in termination of the continuation coverage in accordance with the
33 applicable provisions in the plan's group subscriber agreement
34 with the employer or former employer.

35 (2) The continuation coverage for the former spouse shall end
36 automatically on the earlier of (A) the date the individual reaches
37 65 years of age, (B) the date the individual is covered under any
38 group health plan not maintained by the employer or any other
39 health plan, regardless of whether that coverage is less valuable,
40 (C) the date the individual becomes entitled to Medicare under

1 Title XVIII of the Social Security Act, (D) five years from the date
2 on which continuation coverage under COBRA or Cal-COBRA
3 was scheduled to end for the former spouse, or (E) the date on
4 which the employer or former employer terminates its group
5 subscriber agreement with the health care service plan and ceases
6 to provide coverage for any active employees through that plan.

7 (d) (1) If the premium charged to the employer for a specific
8 employee or dependent eligible under this section is adjusted for
9 the age of the specific employee, or eligible dependent, on other
10 than a composite basis, the rate for continuation coverage under
11 this section shall not exceed 102 percent of the premium charged
12 by the plan to the employer for an employee of the same age as
13 the former employee electing continuation coverage in the case of
14 an individual who was eligible for COBRA, and 110 percent in
15 the case of an individual who was eligible for Cal-COBRA. If the
16 coverage continued is that of a former spouse, the premium charged
17 shall not exceed 102 percent of the premium charged by the plan
18 to the employer for an employee of the same age as the former
19 spouse selecting continuation coverage in the case of an individual
20 who was eligible for COBRA, and 110 percent in the case of an
21 individual who was eligible for Cal-COBRA.

22 (2) If the premium charged to the employer for a specific
23 employee or dependent eligible under this section is not adjusted
24 for age of the specific employee, or eligible dependent, then the
25 rate for continuation coverage under this section shall not exceed
26 213 percent of the applicable current group rate. For purposes of
27 this section, the “applicable current group rate” means the total
28 premiums charged by the health care service plan for coverage for
29 the group, divided by the relevant number of covered persons.

30 (3) However, in computing the premiums charged to the specific
31 employer group, the health care service plan shall not include
32 consideration of the specific medical care expenditures for
33 beneficiaries receiving continuation coverage pursuant to this
34 section.

35 (e) For purposes of this section, “COBRA” means Section
36 4980B of Title 26 of the United States Code, Section 1161 et seq.
37 of Title 29 of the United States Code, and Section 300bb of Title
38 42 of the United States Code, as added by the Consolidated
39 Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272),
40 and as amended.

1 (f) For purposes of this section, “Cal-COBRA” means the
2 continuation coverage that must be offered pursuant to Article 4.5
3 (commencing with Section 1366.20), or Article 1.7 (commencing
4 with Section 10128.50) of Chapter 1 of Part 2 of Division 2 of the
5 Insurance Code.

6 (g) For the purposes of this section, “former spouse” means
7 either an individual who is divorced from an employee or former
8 employee or an individual who was married to an employee or
9 former employee at the time of the death of the employee or former
10 employee.

11 (h) Every plan evidence of coverage that is issued, amended,
12 or renewed after July 1, 1999, shall contain a description of the
13 provisions and eligibility requirements for the continuation
14 coverage offered pursuant to this section.

15 (i) This section does not apply to any individual who is not
16 eligible for its continuation coverage prior to January 1, 2005.

17 *SEC. 8. Section 1373.622 of the Health and Safety Code is*
18 *amended to read:*

19 1373.622. (a) (1) After the termination of the pilot program
20 under Section 1373.62, a health care service plan shall continue
21 to provide coverage under the same terms and conditions specified
22 in Section 1376.62 as it existed on January 1, ~~2006~~, 2007, including
23 the terms of the standard benefit plan and the subscriber payment
24 amount, to each individual who was terminated from the program
25 pursuant to subdivision (f) of Section 12725 of the Insurance Code
26 during the term of the pilot program and who enrolled or applied
27 to enroll in a standard benefit plan within 63 days of termination.
28 The Managed Risk Medical Insurance Board shall continue to pay
29 the amount described in Section 1376.62 for each of those
30 individuals. A health care service plan shall not be required to
31 offer the coverage described in Section 1373.62 after the
32 termination of the pilot program to individuals not already enrolled
33 in the program.

34 (2) *Notwithstanding paragraph (1) of this subdivision or section*
35 *1373.62 as it existed on January 1, 2007, the following rules shall*
36 *apply:*

37 (A) (i) *A health care service plan shall not be obligated to*
38 *provide coverage to any individual pursuant to this section on or*
39 *after January 1, 2014.*

1 (ii) *The Managed Risk Medical Insurance Board shall not be*
2 *obligated to provide any payment to any health care service plan*
3 *under this section for (I) health care expenses incurred on or after*
4 *January 1, 2014 or (II) the standard monthly administrative fee,*
5 *as defined in Section 1373.62 as it existed on January 1, 2007, for*
6 *any month after December 2013.*

7 (B) *Each health care service plan providing coverage pursuant*
8 *to this section shall, on or before October 1, 2013, send a notice*
9 *to each individual enrolled in a standard benefit plan that is in at*
10 *least 12-point type and with, at minimum, the following*
11 *information:*

12 (i) *Notice that, as of December 31, 2012, the plan will terminate.*

13 (ii) *The availability of individual health coverage through*
14 *Covered California, including at least all of the following:*

15 (I) *That, beginning on January 1, 2014, individuals seeking*
16 *coverage may not be denied coverage based on health status.*

17 (II) *That the premium rates for coverage offered by a health*
18 *care service plan or a health insurer cannot be based on an*
19 *individual's health status.*

20 (III) *That individuals obtaining coverage through Covered*
21 *California may, depending upon income, be eligible for premium*
22 *subsidies and cost-sharing subsidies.*

23 (IV) *That individuals seeking coverage must obtain this coverage*
24 *during an open or special enrollment period, and a description of*
25 *the open and special enrollment periods that may apply.*

26 (C) *As a condition of receiving payment for a reporting period*
27 *pursuant to this section, a health care service plan shall provide*
28 *the Managed Risk Medical Insurance Board with a complete, final*
29 *annual reconciliation report by the earlier of December 31, 2014,*
30 *or an earlier date as prescribed by Section 1373.62, as it existed*
31 *on January 1, 2007, for that reporting period. To the extent that*
32 *it receives a complete, final reconciliation report for a reporting*
33 *period by the date required pursuant to this subparagraph, the*
34 *Managed Risk Medical Insurance Board shall complete*
35 *reconciliation with the health care service plan for that reporting*
36 *period within six months of receiving the report.*

37 (b) *If the state fails to expend, pursuant to this section, sufficient*
38 *funds for the state's contribution amount to any health care service*
39 *plan, the health care service plan may increase the monthly*
40 *payments that its subscribers are required to pay for any standard*

1 benefit plan to the amount that the Managed Risk Medical
2 Insurance Board would charge without a state subsidy for the same
3 plan issued to the same individual within the program.

4 *(c) The adoption and readoption, by the Managed Risk Medical*
5 *Insurance Board, of regulations implementing the amendments to*
6 *this section enacted by the legislation adding this subdivision shall*
7 *be deemed an emergency and necessary to avoid serious harm to*
8 *the public peace, health, safety, or general welfare for purposes*
9 *of Sections 11346.1 and 11349.6 of the Government Code, and*
10 *the Managed Risk Medical Insurance Board is hereby exempted*
11 *from the requirement that it describe facts showing the need for*
12 *immediate action and from review by the Office of Administrative*
13 *Law.*

14 ~~SEC. 8:~~

15 *SEC. 9.* Section 1389.5 of the Health and Safety Code is
16 amended to read:

17 1389.5. (a) This section shall apply to a health care service
18 plan that provides coverage under an individual plan contract that
19 is issued, amended, delivered, or renewed on or after January 1,
20 2007.

21 (b) At least once each year, the health care service plan shall
22 permit an individual who has been covered for at least 18 months
23 under an individual plan contract to transfer, without medical
24 underwriting, to any other individual plan contract offered by that
25 same health care service plan that provides equal or lesser benefits,
26 as determined by the plan.

27 “Without medical underwriting” means that the health care
28 service plan shall not decline to offer coverage to, or deny
29 enrollment of, the individual or impose any preexisting condition
30 exclusion on the individual who transfers to another individual
31 plan contract pursuant to this section.

32 (c) The plan shall establish, for the purposes of subdivision (b),
33 a ranking of the individual plan contracts it offers to individual
34 purchasers and post the ranking on its Internet Web site or make
35 the ranking available upon request. The plan shall update the
36 ranking whenever a new benefit design for individual purchasers
37 is approved.

38 (d) The plan shall notify in writing all enrollees of the right to
39 transfer to another individual plan contract pursuant to this section,
40 at a minimum, when the plan changes the enrollee’s premium rate.

1 Posting this information on the plan's Internet Web site shall not
2 constitute notice for purposes of this subdivision. The notice shall
3 adequately inform enrollees of the transfer rights provided under
4 this section, including information on the process to obtain details
5 about the individual plan contracts available to that enrollee and
6 advising that the enrollee may be unable to return to his or her
7 current individual plan contract if the enrollee transfers to another
8 individual plan contract.

9 (e) The requirements of this section shall not apply to the
10 following:

11 (1) A federally eligible defined individual, as defined in
12 subdivision (c) of Section 1399.801, who is enrolled in an
13 individual health benefit plan contract offered pursuant to Section
14 1366.35.

15 (2) An individual offered conversion coverage pursuant to
16 Section 1373.6.

17 (3) Individual coverage under a specialized health care service
18 plan contract.

19 (4) An individual enrolled in the Medi-Cal program pursuant
20 to Chapter 7 (commencing with Section 14000) of Division 9 of
21 Part 3 of the Welfare and Institutions Code.

22 (5) An individual enrolled in the Access for Infants and Mothers
23 Program pursuant to Part 6.3 (commencing with Section 12695)
24 of Division 2 of the Insurance Code.

25 (6) An individual enrolled in the Healthy Families Program
26 pursuant to Part 6.2 (commencing with Section 12693) of Division
27 2 of the Insurance Code.

28 (f) It is the intent of the Legislature that individuals shall have
29 more choice in their health coverage when health care service plans
30 guarantee the right of an individual to transfer to another product
31 based on the plan's own ranking system. The Legislature does not
32 intend for the department to review or verify the plan's ranking
33 for actuarial or other purposes.

34 (g) (1) This section shall be inoperative on January 1, 2014.

35 (2) If Section 5000A of the Internal Revenue Code, as added
36 by Section 1501 of PPACA, is repealed or amended to no longer
37 apply to the individual market, as defined in Section 2791 of the
38 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this
39 section shall become operative on the date of that repeal or
40 amendment.

1 (3) For purposes of this subdivision, “PPACA” means the federal
2 Patient Protection and Affordable Care Act (Public Law 111-148),
3 as amended by the federal Health Care and Education
4 Reconciliation Act of 2010 (Public Law 111-152), and any rules,
5 regulations, or guidance issued pursuant to that law.

6 ~~SEC. 9.~~

7 *SEC. 10.* Section 1399.805 of the Health and Safety Code is
8 amended to read:

9 1399.805. (a) ~~(1)~~—After the federally eligible defined
10 individual submits a completed application form for a plan contract,
11 the plan shall, within 30 days, notify the individual of the
12 individual’s actual premium charges for that plan contract, unless
13 the plan has provided notice of the premium charge prior to the
14 application being filed. In no case shall the premium charged for
15 any health care service plan contract identified in subdivision (d)
16 of Section 1366.35 exceed the following amounts:

17 ~~(A) For health care service plan contracts that offer services~~
18 ~~through a preferred provider arrangement, the average premium~~
19 ~~paid by a subscriber of the Major Risk Medical Insurance Program~~
20 ~~who is of the same age and resides in the same geographic area as~~
21 ~~the federally eligible defined individual. However, for federally~~
22 ~~qualified individuals who are between the ages of 60 and 64,~~
23 ~~inclusive, the premium shall not exceed the average premium paid~~
24 ~~by a subscriber of the Major Risk Medical Insurance Program who~~
25 ~~is 59 years of age and resides in the same geographic area as the~~
26 ~~federally eligible defined individual.~~

27 ~~(B) For health care service plan contracts identified in~~
28 ~~subdivision (d) of Section 1366.35 that do not offer services~~
29 ~~through a preferred provider arrangement, 170 percent of the~~
30 ~~standard premium charged to an individual who is of the same age~~
31 ~~and resides in the same geographic area as the federally eligible~~
32 ~~defined individual. However, for federally qualified individuals~~
33 ~~who are between the ages of 60 and 64, inclusive, the premium~~
34 ~~shall not exceed 170 percent of the standard premium charged to~~
35 ~~an individual who is 59 years of age and resides in the same~~
36 ~~geographic area as the federally eligible defined individual. The~~
37 ~~individual shall have 30 days in which to exercise the right to buy~~
38 ~~coverage at the quoted premium rates.~~

39 ~~(2) A plan may adjust the premium based on family size, not to~~
40 ~~exceed the following amounts:~~

1 ~~(A) For health care service plans that offer services through a~~
2 ~~preferred provider arrangement, the average of the Major Risk~~
3 ~~Medical Insurance Program rate for families of the same size that~~
4 ~~reside in the same geographic area as the federally eligible defined~~
5 ~~individual.~~

6 ~~(B) For health care service plans identified in subdivision (d)~~
7 ~~of Section 1366.35 that do not offer services through a preferred~~
8 ~~provider arrangement, 170 percent of the standard premium charged~~
9 ~~to a family that is of the same size and resides in the same~~
10 ~~geographic area as the federally eligible defined individual.~~

11 ~~(1) With respect to the rate charged for coverage provided in~~
12 ~~2014, the rate charged in 2013 for that coverage multiplied by~~
13 ~~1.09.~~

14 ~~(2) With respect to the rate charged for coverage provided in~~
15 ~~2015 and each subsequent year, the rate charged in the prior year~~
16 ~~multiplied by a factor of one plus the percentage change in the~~
17 ~~statewide average premium for the second lowest cost silver plan~~
18 ~~offered on the Exchange. The Exchange shall determine the~~
19 ~~percentage change in the statewide average premium for the~~
20 ~~second lowest cost silver plan by subtracting subparagraphs (A)~~
21 ~~from subparagraph (B) and dividing the result by subparagraph~~
22 ~~(A).~~

23 ~~(A) The average of the premiums charged in the year prior to~~
24 ~~the applicable year for the second lowest cost silver plan in all 19~~
25 ~~rating regions, with the premium for each region weighted based~~
26 ~~on the region's relative share of the Exchange's total individual~~
27 ~~enrollment according to the latest data available to the Exchange.~~

28 ~~(B) The average of the premiums to be charged in the applicable~~
29 ~~year for the second lowest cost silver plan in all 19 rating regions,~~
30 ~~with the premium for each region weighted based on the region's~~
31 ~~relative share of the Exchange's total individual enrollment~~
32 ~~according to the latest data available to the Exchange.~~

33 ~~(3) The Exchange shall determine the percentage change in the~~
34 ~~statewide average premium no later than 30 days after the~~
35 ~~Exchange's rates for individual coverage for the applicable year~~
36 ~~have been finalized.~~

37 ~~(b) When a federally eligible defined individual submits a~~
38 ~~premium payment, based on the quoted premium charges, and that~~
39 ~~payment is delivered or postmarked, whichever occurs earlier,~~
40 ~~within the first 15 days of the month, coverage shall begin no later~~

1 than the first day of the following month. When that payment is
2 neither delivered or postmarked until after the 15th day of a month,
3 coverage shall become effective no later than the first day of the
4 second month following delivery or postmark of the payment.

5 (c) During the first 30 days after the effective date of the plan
6 contract, the individual shall have the option of changing coverage
7 to a different plan contract offered by the same health care service
8 plan. If the individual notified the plan of the change within the
9 first 15 days of a month, coverage under the new plan contract
10 shall become effective no later than the first day of the following
11 month. If an enrolled individual notified the plan of the change
12 after the 15th day of a month, coverage under the new plan contract
13 shall become effective no later than the first day of the second
14 month following notification.

15 (d) (1) On and after January 1, 2014, and except as provided
16 in paragraph (2), this section shall apply only to individual
17 grandfathered health plan contracts previously issued pursuant to
18 this section to federally eligible defined individuals.

19 (2) If Section 5000A of the Internal Revenue Code, as added
20 by Section 1501 of PPACA, is repealed or amended to no longer
21 apply to the individual market, as defined in Section 2791 of the
22 federal Public Health Service Act (42 U.S.C. Section 300gg-91),
23 paragraph (1) shall become inoperative on the date of that repeal
24 or amendment and this section shall apply to health care service
25 plan contracts issued, amended, or renewed on or after that date.

26 (3) For purposes of this subdivision, the following definitions
27 apply:

28 (A) "Grandfathered health plan" has the same meaning as that
29 term is defined in Section 1251 of the PPACA.

30 (B) "PPACA" means the federal Patient Protection and
31 Affordable Care Act (Public Law 111-148), as amended by the
32 federal Health Care Education and Reconciliation Act of 2010
33 (Public Law 111-152), and any rules, regulations, or guidance
34 issued pursuant to that law.

35 ~~SEC. 10.~~

36 *SEC. 11.* Section 1399.810 of the Health and Safety Code is
37 amended to read:

38 1399.810. All health care service plan contracts offered to a
39 federally eligible defined individual shall be renewable with respect

1 to the individual and dependents at the option of the contractholder
2 except in cases of:

3 (a) Nonpayment of the required premiums.

4 (b) Fraud or misrepresentation by the contractholder.

5 (c) The plan ceases to provide or arrange for the provision of
6 health care services for individual health care service plan contracts
7 in this state, provided, however, that the following conditions are
8 satisfied:

9 (1) Notice of the decision to cease new or existing individual
10 health benefit plans in this state is provided to the director and to
11 the contractholder.

12 (2) Individual health care service plan contracts subject to this
13 chapter shall not be canceled for 180 days after the date of the
14 notice required under paragraph (1) and for that business of a plan
15 that remains in force, any plan that ceases to offer for sale new
16 individual health care service plan contracts shall continue to be
17 governed by this article with respect to business conducted under
18 this article.

19 (3) A plan that ceases to write new individual business in this
20 state after January 1, 2001, shall be prohibited from offering for
21 sale new individual health care service plan contracts in this state
22 for a period of three years from the date of the notice to the director.

23 (d) When the plan withdraws a health care service plan contract
24 from the individual market, provided that the plan makes available
25 to eligible individuals all plan contracts that it makes available to
26 new individual business, and provided that the premium for the
27 new plan contract complies with the renewal increase requirements
28 set forth in Section 1399.811.

29 (e) (1) On and after January 1, 2014, and except as provided
30 in paragraph (2), this section shall apply only to individual
31 grandfathered health plan contracts previously issued pursuant to
32 this section to federally eligible defined individuals.

33 (2) If Section 5000A of the Internal Revenue Code, as added
34 by Section 1501 of PPACA, is repealed or amended to no longer
35 apply to the individual market, as defined in Section 2791 of the
36 federal Public Health Service Act (42 U.S.C. Section 300gg-91),
37 paragraph (1) shall become inoperative on the date of that repeal
38 or amendment and this section shall apply to health care service
39 plan contracts issued, amended, or renewed on or after that date.

(3) For purposes of this subdivision, the following definitions apply:

(A) “Grandfathered health plan” has the same meaning as that term is defined in Section 1251 of the PPACA.

(B) “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care Education and Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

~~SEC. 11.~~

SEC. 12. Section 1399.811 of the Health and Safety Code is amended to read:

1399.811. Premiums for contracts offered, delivered, amended, or renewed by plans on or after January 1, 2001, shall be subject to the following requirements:

(a) The premium for new business for a federally eligible defined individual shall not exceed the following amounts:

(1) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 to 64 years, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(2) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 to 64 years, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(b) The premium for in force business for a federally eligible defined individual shall not exceed the following amounts:

(1) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64 years, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.

(2) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64 years, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual. The premium effective on January 1, 2001, shall apply to in force business at the earlier of either the time of renewal or July 1, 2001.

(c) The premium applied to a federally eligible defined individual may not increase by more than the following amounts:

(1) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that offer services through a preferred provider arrangement, the average increase in the premiums charged to a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual.

(2) For health care service plan contracts identified in subdivision (d) of Section 1366.35 that do not offer services through a preferred provider arrangement, the increase in premiums charged to a nonfederally qualified individual who is of the same age and resides in the same geographic area as the federally defined eligible individual. The premium for an eligible individual may not be modified more frequently than every 12 months.

(3) For a contract that a plan has discontinued offering, the premium applied to the first rating period of the new contract that

1 the federally eligible defined individual elects to purchase shall
2 be no greater than the premium applied in the prior rating period
3 to the discontinued contract.

4 (d) (1) On and after January 1, 2014, and except as provided
5 in paragraph (2), this section shall apply only to individual
6 grandfathered health plan contracts previously issued pursuant to
7 this section to federally eligible defined individuals.

8 (2) If Section 5000A of the Internal Revenue Code, as added
9 by Section 1501 of PPACA, is repealed or amended to no longer
10 apply to the individual market, as defined in Section 2791 of the
11 federal Public Health Service Act (42 U.S.C. Section 300gg-91),
12 paragraph (1) shall become inoperative on the date of that repeal
13 or amendment and this section shall apply to health care service
14 plan contracts issued, amended, or renewed on or after that date.

15 (3) For purposes of this subdivision, the following definitions
16 apply:

17 (A) "Grandfathered health plan" has the same meaning as that
18 term is defined in Section 1251 of the PPACA.

19 (B) "PPACA" means the federal Patient Protection and
20 Affordable Care Act (Public Law 111-148), as amended by the
21 federal Health Care Education and Reconciliation Act of 2010
22 (Public Law 111-152), and any rules, regulations, or guidance
23 issued pursuant to that law.

24 ~~SEC. 12.~~

25 *SEC. 13.* Section 1399.815 of the Health and Safety Code is
26 amended to read:

27 1399.815. (a) At least 20 business days prior to renewing or
28 amending a plan contract subject to this article, or at least 20
29 business days prior to the initial offering of a plan contract subject
30 to this article, a plan shall file a notice of an amendment with the
31 director in accordance with the provisions of Section 1352. The
32 notice of an amendment shall include a statement certifying that
33 the plan is in compliance with subdivision (a) of Section 1399.805
34 and with Section 1399.811. Any action by the director, as permitted
35 under Section 1352, to disapprove, suspend, or postpone the plan's
36 use of a plan contract shall be in writing, specifying the reasons
37 the plan contract does not comply with the requirements of this
38 chapter.

39 (b) Prior to making any changes in the premium, the plan shall
40 file an amendment in accordance with the provisions of Section

1 1352, and shall include a statement certifying the plan is in
2 compliance with subdivision (a) of Section 1399.805 and with
3 Section 1399.811. All other changes to a plan contract previously
4 filed with the director pursuant to subdivision (a) shall be filed as
5 an amendment in accordance with the provisions of Section 1352,
6 unless the change otherwise would require the filing of a material
7 modification.

8 (c) (1) On and after January 1, 2014, and except as provided
9 in paragraph (2), this section shall apply only to individual
10 grandfathered health plan contracts previously issued pursuant to
11 this section to federally eligible defined individuals.

12 (2) If Section 5000A of the Internal Revenue Code, as added
13 by Section 1501 of PPACA, is repealed or amended to no longer
14 apply to the individual market, as defined in Section 2791 of the
15 federal Public Health Service Act (42 U.S.C. Section 300gg-91),
16 paragraph (1) shall become inoperative on the date of that repeal
17 or amendment and this section shall apply to plan contracts issued,
18 amended, or renewed on or after that date.

19 (3) For purposes of this subdivision, the following definitions
20 apply:

21 (A) "Grandfathered health plan" has the same meaning as that
22 term is defined in Section 1251 of the PPACA.

23 (B) "PPACA" means the federal Patient Protection and
24 Affordable Care Act (Public Law 111-148), as amended by the
25 federal Health Care Education and Reconciliation Act of 2010
26 (Public Law 111-152), and any rules, regulations, or guidance
27 issued pursuant to that law.

28 ~~SEC. 13.~~

29 *SEC. 14.* Section 10116.5 of the Insurance Code is amended
30 to read:

31 10116.5. (a) Every policy of disability insurance that is issued,
32 amended, delivered, or renewed in this state on or after January
33 1, 1999, that provides hospital, medical, or surgical expense
34 coverage under an employer-sponsored group plan for an employer
35 subject to COBRA, as defined in subdivision (e), or an employer
36 group for which the disability insurer is required to offer
37 Cal-COBRA coverage, as defined in subdivision (f), including a
38 carrier providing replacement coverage under Section 10128.3,
39 shall further offer the former employee the opportunity to continue
40 benefits as required under subdivision (b), and shall further offer

1 the former spouse of an employee or former employee the
2 opportunity to continue benefits as required under subdivision (c).

3 (b) (1) If a former employee worked for the employer for at
4 least five years prior to the date of termination of employment and
5 is 60 years of age or older on the date employment ends is entitled
6 to and so elects to continue benefits under COBRA or Cal-COBRA
7 for himself or herself and for any spouse, the employee or spouse
8 may further continue benefits beyond the date coverage under
9 COBRA or Cal-COBRA ends, as set forth in paragraph (2). Except
10 as otherwise specified in this section, continuation coverage shall
11 be under the same benefit terms and conditions as if the
12 continuation coverage under COBRA or Cal-COBRA had remained
13 in force. For the employee or spouse, continuation coverage
14 following the end of COBRA or Cal-COBRA is subject to payment
15 of premiums to the insurer. Individuals ineligible for COBRA or
16 Cal-COBRA or who are eligible but have not elected or exhausted
17 continuation coverage under federal COBRA or Cal-COBRA are
18 not entitled to continuation coverage under this section. Premiums
19 for continuation coverage under this section shall be billed by, and
20 remitted to, the insurer in accordance with subdivision (d). Failure
21 to pay the requisite premiums may result in termination of the
22 continuation coverage in accordance with the applicable provisions
23 in the insurer's group contract with the employer.

24 (2) The employer shall notify the former employee or spouse
25 or both, or the former spouse of the employee or former employee,
26 of the availability of the continuation benefits under this section
27 in accordance with Section 2800.2 of the Labor Code. To continue
28 health care coverage pursuant to this section, the individual shall
29 elect to do so by notifying the insurer in writing within 30 calendar
30 days prior to the date continuation coverage under COBRA or
31 Cal-COBRA is scheduled to end. Every disability insurer shall
32 provide to the employer replacing a group benefit plan policy
33 issued by the insurer, or to the employer's agent or broker
34 representative, within 15 days of any written request, information
35 in possession of the insurer reasonably required to administer the
36 requirements of Section 2800.2 of the Labor Code.

37 (3) The continuation coverage shall end automatically on the
38 earlier of (A) the date the individual reaches age 65, (B) the date
39 the individual is covered under any group health plan not
40 maintained by the employer or any other insurer or health care

1 service plan, regardless of whether that coverage is less valuable,
2 (C) the date the individual becomes entitled to Medicare under
3 Title XVIII of the Social Security Act, (D) for a spouse, five years
4 from the date on which continuation coverage under COBRA or
5 Cal-COBRA was scheduled to end for the spouse, or (E) the date
6 on which the employer terminates its group contract with the
7 insurer and ceases to provide coverage for any active employees
8 through that insurer, in which case the insurer shall notify the
9 former employee or spouse, or both, of the right to a conversion
10 policy.

11 (c) (1) If a former spouse of an employee or former employee
12 was covered as a qualified beneficiary under COBRA or
13 Cal-COBRA, the former spouse may further continue benefits
14 beyond the date coverage under COBRA or Cal-COBRA ends, as
15 set forth in paragraph (2) of subdivision (b). Except as otherwise
16 specified in this section, continuation coverage shall be under the
17 same benefit terms and conditions as if the continuation coverage
18 under COBRA or Cal-COBRA had remained in force. Continuation
19 coverage following the end of COBRA or Cal-COBRA is subject
20 to payment of premiums to the insurer. Premiums for continuation
21 coverage under this section shall be billed by, and remitted to, the
22 insurer in accordance with subdivision (d). Failure to pay the
23 requisite premiums may result in termination of the continuation
24 coverage in accordance with the applicable provisions in the
25 insurer's group contract with the employer or former employer.

26 (2) The continuation coverage for the former spouse shall end
27 automatically on the earlier of (A) the date the individual reaches
28 65 years of age, (B) the date the individual is covered under any
29 group health plan not maintained by the employer or any other
30 health care service plan or insurer, regardless of whether that
31 coverage is less valuable, (C) the date the individual becomes
32 entitled to Medicare under Title XVIII of the Social Security Act,
33 (D) five years from the date on which continuation coverage under
34 COBRA or Cal-COBRA was scheduled to end for the former
35 spouse, or (E) the date on which the employer or former employer
36 terminates its group contract with the insurer and ceases to provide
37 coverage for any active employees through that insurer.

38 (d) (1) If the premium charged to the employer for a specific
39 employee or dependent eligible under this section is adjusted for
40 the age of the specific employee, or eligible dependent, on other

1 than a composite basis, the rate for continuation coverage under
2 this section shall not exceed 102 percent of the premium charged
3 by the insurer to the employer for an employee of the same age as
4 the former employee electing continuation coverage in the case of
5 an individual who was eligible for COBRA, and 110 percent in
6 the case of an individual who was eligible for Cal-COBRA. If the
7 coverage continued is that of a former spouse, the premium charged
8 shall not exceed 102 percent of the premium charged by the plan
9 to the employer for an employee of the same age as the former
10 spouse selecting continuation coverage in the case of an individual
11 who was eligible for COBRA, and 110 percent in the case of an
12 individual who was eligible for Cal-COBRA.

13 (2) If the premium charged to the employer for a specific
14 employee or dependent eligible under this section is not adjusted
15 for age of the specific employee, or eligible dependent, then the
16 rate for continuation coverage under this section shall not exceed
17 213 percent of the applicable current group rate. For purposes of
18 this section, the “applicable current group rate” means the total
19 premiums charged by the insurer for coverage for the group,
20 divided by the relevant number of covered persons.

21 (3) However, in computing the premiums charged to the specific
22 employer group, the insurer shall not include consideration of the
23 specific medical care expenditures for beneficiaries receiving
24 continuation coverage pursuant to this section.

25 (e) For purposes of this section, “COBRA” means Section
26 4980B of Title 26, Section 1161 and following of Title 29, and
27 Section 300bb of Title 42 of the United States Code, as added by
28 the Consolidated Omnibus Budget Reconciliation Act of 1985
29 (Public Law 99-272), and as amended.

30 (f) For purposes of this section, “Cal-COBRA” means the
31 continuation coverage that must be offered pursuant to Article 1.7
32 (commencing with Section 10128.50), or Article 4.5 (commencing
33 with Section 1366.20) of Chapter 2.2 of Division 2 of the Health
34 and Safety Code.

35 (g) For the purposes of this section, “former spouse” means
36 either an individual who is divorced from an employee or former
37 employee or an individual who was married to an employee or
38 former employee at the time of the death of the employee or former
39 employee.

1 (h) Every group benefit plan evidence of coverage that is issued,
2 amended, or renewed after January 1, 1999, shall contain a
3 description of the provisions and eligibility requirements for the
4 continuation coverage offered pursuant to this section.

5 (i) This section does not apply to any individual who is not
6 eligible for its continuation coverage prior to January 1, 2005.

7 ~~SEC. 14.~~

8 *SEC. 15.* Section 10119.1 of the Insurance Code is amended
9 to read:

10 10119.1. (a) This section shall apply to a health insurer that
11 covers hospital, medical, or surgical expenses under an individual
12 health benefit plan, as defined in subdivision (a) of Section
13 10198.6, that is issued, amended, renewed, or delivered on or after
14 January 1, 2007.

15 (b) At least once each year, a health insurer shall permit an
16 individual who has been covered for at least 18 months under an
17 individual health benefit plan to transfer, without medical
18 underwriting, to any other individual health benefit plan offered
19 by that same health insurer that provides equal or lesser benefits
20 as determined by the insurer.

21 “Without medical underwriting” means that the health insurer
22 shall not decline to offer coverage to, or deny enrollment of, the
23 individual or impose any preexisting condition exclusion on the
24 individual who transfers to another individual health benefit plan
25 pursuant to this section.

26 (c) The insurer shall establish, for the purposes of subdivision
27 (b), a ranking of the individual health benefit plans it offers to
28 individual purchasers and post the ranking on its Internet Web site
29 or make the ranking available upon request. The insurer shall
30 update the ranking whenever a new benefit design for individual
31 purchasers is approved.

32 (d) The insurer shall notify in writing all insureds of the right
33 to transfer to another individual health benefit plan pursuant to
34 this section, at a minimum, when the insurer changes the insured’s
35 premium rate. Posting this information on the insurer’s Internet
36 Web site shall not constitute notice for purposes of this subdivision.
37 The notice shall adequately inform insureds of the transfer rights
38 provided under this section including information on the process
39 to obtain details about the individual health benefit plans available
40 to that insured and advising that the insured may be unable to

1 return to his or her current individual health benefit plan if the
2 insured transfers to another individual health benefit plan.

3 (e) The requirements of this section shall not apply to the
4 following:

5 (1) A federally eligible defined individual, as defined in
6 subdivision (e) of Section 10900, who purchases individual
7 coverage pursuant to Section 10785.

8 (2) An individual offered conversion coverage pursuant to
9 Sections 12672 and 12682.1.

10 (3) An individual enrolled in the Medi-Cal program pursuant
11 to Chapter 7 (commencing with Section 14000) of Part 3 of
12 Division 9 of the Welfare and Institutions Code.

13 (4) An individual enrolled in the Access for Infants and Mothers
14 Program, pursuant to Part 6.3 (commencing with Section 12695).

15 (5) An individual enrolled in the Healthy Families Program
16 pursuant to Part 6.2 (commencing with Section 12693).

17 (f) It is the intent of the Legislature that individuals shall have
18 more choice in their health care coverage when health insurers
19 guarantee the right of an individual to transfer to another product
20 based on the insurer's own ranking system. The Legislature does
21 not intend for the department to review or verify the insurer's
22 ranking for actuarial or other purposes.

23 (g) (1) This section shall be inoperative on January 1, 2014.

24 (2) If Section 5000A of the Internal Revenue Code, as added
25 by Section 1501 of PPACA, is repealed or amended to no longer
26 apply to the individual market, as defined in Section 2791 of the
27 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this
28 section shall become operative on the date of that repeal or
29 amendment.

30 (3) For purposes of this subdivision, "PPACA" means the federal
31 Patient Protection and Affordable Care Act (Public Law 111-148),
32 as amended by the federal Health Care and Education
33 Reconciliation Act of 2010 (Public Law 111-152), and any rules,
34 regulations, or guidance issued pursuant to that law.

35 ~~SEC. 15.~~

36 *SEC. 16.* Section 10127.14 of the Insurance Code is amended
37 to read:

38 10127.14. (a) The department and the Department of Managed
39 Health Care shall compile information required by this section and
40 Section 1363.06 of the Health and Safety Code into two

1 comparative benefit matrices. The first matrix shall compare benefit
2 packages offered pursuant to Section 1373.62 of the Health and
3 Safety Code and Section 10127.15. The second matrix shall
4 compare benefit packages offered pursuant to Sections 1366.35,
5 1373.6, and 1399.804 of the Health and Safety Code and Sections
6 10785, 10901.2, and 12682.1.

7 (b) The comparative benefit matrix shall include:

8 (1) Benefit information submitted by health care service plans
9 pursuant to Section 1363.06 of the Health and Safety Code and by
10 health insurers pursuant to subdivision (d).

11 (2) The following statements in at least 12-point type at the top
12 of the matrix:

13 (A) "This benefit summary is intended to help you compare
14 coverage and benefits and is a summary only. For a more detailed
15 description of coverage, benefits, and limitations, please contact
16 the health care service plan or health insurer."

17 (B) "The comparative benefit summary is updated annually, or
18 more often if necessary to be accurate."

19 (C) "The most current version of this comparative benefit
20 summary is available on (address of the plan's or insurer's site)."

21 This subparagraph applies only to those health insurers that
22 maintain an Internet Web site.

23 (3) The telephone number or numbers that may be used by an
24 applicant to contact either the department or the Department of
25 Managed Health Care, as appropriate, for further assistance.

26 (c) The department and the Department of Managed Health
27 Care shall jointly prepare two standardized templates for use by
28 health care service plans and health insurers in submitting the
29 information required pursuant to subdivision (d) of Section 1363.06
30 and subdivision (d). The templates shall be exempt from the
31 provisions of Chapter 3.5 (commencing with Section 11340) of
32 Part 1 of Division 3 of Title 2 of the Government Code.

33 (d) Health insurers shall submit the following to the department
34 by January 31, 2003, and annually thereafter:

35 (1) A summary explanation of the following for each product
36 described in subdivision (a):

37 (A) Eligibility requirements.

38 (B) The full premium cost of each benefit package in the service
39 area in which the individual and eligible dependents work or reside.

40 (C) When and under what circumstances benefits cease.

1 (D) The terms under which coverage may be renewed.

2 (E) Other coverage that may be available if benefits under the
3 described benefit package cease.

4 (F) The circumstances under which choice in the selection of
5 physicians and providers is permitted.

6 (G) Lifetime and annual maximums.

7 (H) Deductibles.

8 (2) A summary explanation of the following coverages, together
9 with the corresponding copayments and limitations, for each
10 product described in subdivision (a):

11 (A) Professional services.

12 (B) Outpatient services.

13 (C) Hospitalization services.

14 (D) Emergency health coverage.

15 (E) Ambulance services.

16 (F) Prescription drug coverage.

17 (G) Durable medical equipment.

18 (H) Mental health services.

19 (I) Residential treatment.

20 (J) Chemical dependency services.

21 (K) Home health services.

22 (L) Custodial care and skilled nursing facilities.

23 (3) The telephone number or numbers that may be used by an
24 applicant to access a health insurer customer service representative
25 and to request additional information about the insurance policy.

26 (4) Any other information specified by the department in the
27 template.

28 (e) Each health insurer shall provide the department with updates
29 to the information required by subdivision (d) at least annually, or
30 more often if necessary to maintain the accuracy of the information.

31 (f) The department and the Department of Managed Health Care
32 shall make the comparative benefit matrices available on their
33 respective Internet Web sites and to the health care service plans
34 and health insurers for dissemination as required by Section 1373.6
35 of the Health and Safety Code and Section 12682.1, after
36 confirming the accuracy of the description of the matrices with
37 the health insurers and health care service plans.

38 (g) As used in this section, “benefit matrix” shall have the same
39 meaning as benefit summary.

(h) This section shall not apply to accident-only, specified disease, hospital indemnity, CHAMPUS supplement, long-term care, Medicare supplement, dental-only, or vision-only insurance policies.

(i) (1) This section shall be inoperative on January 1, 2014.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300g-91), this section shall become operative on the date of that repeal or amendment.

(3) For purposes of this subdivision, “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

SEC. 17. Section 10127.16 of the Insurance Code is amended to read:

10127.16. (a) (1) After the termination of the pilot program under Section 10127.15, a health insurer shall continue to provide coverage under the same terms and conditions specified in Section 10127.15 as it existed on January 1, ~~2006~~, 2007, including the terms of the standard benefit plan and the subscriber payment amount, to each individual who was terminated from the program, pursuant to subdivision (f) of Section 12725 of the Insurance Code during the term of the pilot program and who enrolled or applied to enroll in a standard benefit plan within 63 days of termination. The Managed Risk Medical Insurance Board shall continue to pay the amount described in Section 10127.15 for each of those individuals. A health insurer shall not be required to offer the coverage described in Section 10127.15 after the termination of the pilot program to individuals not already enrolled in the program.

(2) *Notwithstanding paragraph (1) of this subdivision or Section 10127.15 as it existed on January 1, 2007, the following rules shall apply:*

(A) (i) *A health care service plan shall not be obligated to provide coverage to any individual pursuant to this section on or after January 1, 2014.*

1 (ii) *The Managed Risk Medical Insurance Board shall not be*
2 *obligated to provide any payment to any health insurer under this*
3 *section for (I) health care expenses incurred on or after January*
4 *1, 2014 or (II) the standard monthly administrative fee, as defined*
5 *in Section 10127.15 as it existed on January 1, 2007, for any month*
6 *after December, 2013.*

7 (B) *Each health insurer providing coverage pursuant to this*
8 *section shall, on or before October 1, 2013, send a notice to each*
9 *individual enrolled in a standard benefit plan that is in at least*
10 *12-point type and with, at minimum, the following information:*

11 (i) *Notice that, as of December 31, 2012, the plan will terminate.*

12 (ii) *The availability of individual health coverage through*
13 *Covered California, including at least all of the following:*

14 (I) *That, beginning on January 1, 2014, individuals seeking*
15 *coverage may not be denied coverage based on health status.*

16 (II) *That the premium rates for coverage offered by a health*
17 *care service plan or a health insurer cannot be based on an*
18 *individual's health status.*

19 (III) *That individuals obtaining coverage through Covered*
20 *California may, depending upon income, be eligible for premium*
21 *subsidies and cost-sharing subsidies.*

22 (IV) *That individuals seeking coverage must obtain this coverage*
23 *during an open or special enrollment period, and a description of*
24 *the open and special enrollment periods that may apply.*

25 (C) *As a condition of receiving payment for a reporting period*
26 *pursuant to this section, a health insurer shall provide the Managed*
27 *Risk Medical Insurance Board with a complete, final annual*
28 *reconciliation report by the earlier of December 31, 2014, or an*
29 *earlier date as prescribed by Section 10127.15, as it existed on*
30 *January 1, 2007, for that reporting period. To the extent that it*
31 *receives a complete, final reconciliation report for a reporting*
32 *period by the date required pursuant to this subparagraph, the*
33 *Managed Risk Medical Insurance Board shall complete*
34 *reconciliation with the health care service plan for that reporting*
35 *period within six months of receiving the report.*

36 (b) *If the state fails to expend, pursuant to this section, sufficient*
37 *funds for the state's contribution amount to any health insurer, the*
38 *health insurer may increase the monthly payments that its*
39 *subscribers are required to pay for any standard benefit plan to the*
40 *amount that the Managed Risk Medical Insurance Board would*

1 charge without a state subsidy for the same insurance product
2 issued to the same individual within the program.

3 *(c) The adoption and readoption, by the Managed Risk Medical*
4 *Insurance Board, of regulations implementing the amendments to*
5 *this section enacted by the legislation adding this subdivision shall*
6 *be deemed an emergency and necessary to avoid serious harm to*
7 *the public peace, health, safety, or general welfare for purposes*
8 *of Sections 11346.1 and 11349.6 of the Government Code, and*
9 *the Managed Risk Medical Insurance Board is hereby exempted*
10 *from the requirement that it describe facts showing the need for*
11 *immediate action and from review by the Office of Administrative*
12 *Law.*

13 ~~SEC. 16.~~

14 *SEC. 18.* Section 10127.18 of the Insurance Code is amended
15 to read:

16 10127.18. (a) On and after January 1, 2005, a health insurer
17 issuing individual policies of health insurance that ceases to offer
18 individual coverage in this state shall offer coverage to the
19 policyholders who had been covered by those policies at the time
20 of withdrawal under the same terms and conditions as provided in
21 paragraph (3) of subdivision (a), paragraphs (2) to (4), inclusive,
22 of subdivision (b), subdivisions (c) to (e), inclusive, and subdivision
23 (h) of Section 12682.1.

24 (b) The department may adopt regulations to implement this
25 section.

26 (c) This section shall not apply when a plan participating in
27 Medi-Cal, Healthy Families, Access for Infants and Mothers, or
28 any other contract between the plan and a government entity no
29 longer contracts with the government entity to provide health
30 coverage in the state, or a specified area of the state, nor shall this
31 section apply when a plan ceases entirely to market, offer, and
32 issue any and all forms of coverage in any part of this state after
33 the effective date of this section.

34 (d) (1) This section shall be inoperative on January 1, 2014.

35 (2) If Section 5000A of the Internal Revenue Code, as added
36 by Section 1501 of PPACA, is repealed or amended to no longer
37 apply to the individual market, as defined in Section 2791 of the
38 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this
39 section shall become operative on the date of that repeal or
40 amendment.

1 (3) For purposes of this subdivision, “PPACA” means the federal
2 Patient Protection and Affordable Care Act (Public Law 111-148),
3 as amended by the federal Health Care and Education
4 Reconciliation Act of 2010 (Public Law 111-152), and any rules,
5 regulations, or guidance issued pursuant to that law.

6 ~~SEC. 17.~~

7 *SEC. 19.* Section 10785 of the Insurance Code is amended to
8 read:

9 10785. (a) A disability insurer that covers hospital, medical,
10 or surgical expenses under an individual health benefit plan as
11 defined in subdivision (a) of Section 10198.6 may not, with respect
12 to a federally eligible defined individual desiring to enroll in
13 individual health insurance coverage, decline to offer coverage to,
14 or deny enrollment of, the individual or impose any preexisting
15 condition exclusion with respect to the coverage.

16 (b) For purposes of this section, “federally eligible defined
17 individual” means an individual who, as of the date on which the
18 individual seeks coverage under this section, meets all of the
19 following conditions:

20 (1) Has had 18 or more months of creditable coverage, and
21 whose most recent prior creditable coverage was under a group
22 health plan, a federal governmental plan maintained for federal
23 employees, or a governmental plan or church plan as defined in
24 the federal Employee Retirement Income Security Act of 1974
25 (29 U.S.C. Sec. 1002).

26 (2) Is not eligible for coverage under a group health plan,
27 Medicare, or Medi-Cal, and does not have other health insurance
28 coverage.

29 (3) Was not terminated from his or her most recent creditable
30 coverage due to nonpayment of premiums or fraud.

31 (4) If offered continuation coverage under COBRA or
32 Cal-COBRA, has elected and exhausted that coverage.

33 (c) Every disability insurer that covers hospital, medical, or
34 surgical expenses shall comply with applicable federal statutes
35 and regulations regarding the provision of coverage to federally
36 eligible defined individuals, including any relevant application
37 periods.

38 (d) A disability insurer shall offer the following health benefit
39 plans under this section that are designed for, made generally
40 available to, are actively marketed to, and enroll, individuals:

(1) either the two most popular products as defined in Section 300gg-41(c)(2) of Title 42 of the United States Code and Section 148.120(c)(2) of Title 45 of the Code of Federal Regulations or (2) the two most representative products as defined in Section 300gg-41(c)(3) of the United States Code and Section 148.120(c)(3) of Title 45 of the Code of Federal Regulations, as determined by the insurer in compliance with federal law. An insurer that offers only one health benefit plan to individuals, excluding health benefit plans offered to Medi-Cal or Medicare beneficiaries, shall be deemed to be in compliance with this chapter if it offers that health benefit plan contract to federally eligible defined individuals in a manner consistent with this chapter.

(e) (1) In the case of a disability insurer that offers health benefit plans in the individual market through a network plan, the insurer may do both of the following:

(A) Limit the individuals who may be enrolled under that coverage to those who live, reside, or work within the service area for the network plan.

(B) Within the service area covered by the health benefit plan, deny coverage to individuals if the insurer has demonstrated to the commissioner that the insured will not have the capacity to deliver services adequately to additional individual insureds because of its obligations to existing group policyholders, group contractholders and insureds, and individual insureds, and that the insurer is applying this paragraph uniformly to individuals without regard to any health status-related factor of the individuals and without regard to whether the individuals are federally eligible defined individuals.

(2) A disability insurer, upon denying health insurance coverage in any service area in accordance with subparagraph (B) of paragraph (1), may not offer health benefit plans through a network in the individual market within that service area for a period of 180 days after the coverage is denied.

(f) (1) A disability insurer may deny health insurance coverage in the individual market to a federally eligible defined individual if the insurer has demonstrated to the commissioner both of the following:

(A) The insurer does not have the financial reserves necessary to underwrite additional coverage.

1 (B) The insurer is applying this subdivision uniformly to all
2 individuals in the individual market and without regard to any
3 health status-related factor of the individuals and without regard
4 to whether the individuals are federally eligible defined individuals.

5 (2) A disability insurer, upon denying individual health
6 insurance coverage in any service area in accordance with
7 paragraph (1), may not offer that coverage in the individual market
8 within that service area for a period of 180 days after the date the
9 coverage is denied or until the insurer has demonstrated to the
10 commissioner that the insurer has sufficient financial reserves to
11 underwrite additional coverage, whichever is later.

12 (g) The requirement pursuant to federal law to furnish a
13 certificate of creditable coverage shall apply to health benefits
14 plans offered by a disability insurer in the individual market in the
15 same manner as it applies to an insurer in connection with a group
16 health benefit plan policy or group health benefit plan contract.

17 (h) A disability insurer shall compensate a life agent, property
18 broker-agent, or casualty broker-agent whose activities result in
19 the enrollment of federally eligible defined individuals in the same
20 manner and consistent with the renewal commission amounts as
21 the insurer compensates life agents, property broker-agents, or
22 casualty broker-agents for other enrollees who are not federally
23 eligible defined individuals and who are purchasing the same
24 individual health benefit plan.

25 (i) Every disability insurer shall disclose as part of its COBRA
26 or Cal-COBRA disclosure and enrollment documents, an
27 explanation of the availability of guaranteed access to coverage
28 under the Health Insurance Portability and Accountability Act of
29 1996, including the necessity to enroll in and exhaust COBRA or
30 Cal-COBRA benefits in order to become a federally eligible
31 defined individual.

32 (j) No disability insurer may request documentation as to
33 whether or not a person is a federally eligible defined individual
34 other than is permitted under applicable federal law or regulations.

35 (k) This section shall not apply to coverage defined as excepted
36 benefits pursuant to Section 300gg(c) of Title 42 of the United
37 States Code.

38 (l) This section shall apply to policies or contracts offered,
39 delivered, amended, or renewed on or after January 1, 2001.

(m) (1) On and after January 1, 2014, and except as provided in paragraph (2), this section shall apply only to individual grandfathered health plans previously issued pursuant to this section to federally eligible defined individuals.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Section 300gg-91), paragraph (1) shall become inoperative on the date of that repeal or amendment and this section shall apply to health benefit plans issued, amended, or renewed on or after that date.

(3) For purposes of this subdivision, the following definitions apply:

(A) "Grandfathered health plan" has the same meaning as that term is defined in Section 1251 of PPACA.

(B) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance ~~issues~~*issued* pursuant to that law.

~~SEC. 18.~~

SEC. 20. Section 10901.3 of the Insurance Code is amended to read:

10901.3. (a) ~~(1)~~ After the federally eligible defined individual submits a completed application form for a health benefit plan, the carrier shall, within 30 days, notify the individual of the individual's actual premium charges for that health benefit plan design. In no case shall the premium charged for any health benefit plan identified in subdivision (d) of Section 10785 exceed the following amounts:

~~(A) For health benefit plans that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64, inclusive, the premium shall not exceed the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is 59 years of age and resides in the same geographic area as the federally eligible defined individual.~~

~~(B) For health benefit plans identified in subdivision (d) of Section 10785 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to an individual who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals who are between the ages of 60 and 64, inclusive, the premium shall not exceed 170 percent of the standard premium charged to an individual who is 59 years of age and resides in the same geographic area as the federally eligible defined individual. The individual shall have 30 days in which to exercise the right to buy coverage at the quoted premium rates.~~

~~(2) A carrier may adjust the premium based on family size, not to exceed the following amounts:~~

~~(A) For health benefit plans that offer services through a preferred provider arrangement, the average of the Major Risk Medical Insurance Program rate for families of the same size that reside in the same geographic area as the federally eligible defined individual.~~

~~(B) For health benefit plans identified in subdivision (d) of Section 10785 that do not offer services through a preferred provider arrangement, 170 percent of the standard premium charged to a family that is of the same size and resides in the same geographic area as the federally eligible defined individual.~~

~~(1) With respect to the rate charged for coverage provided in 2014, the rate charged in 2013 for that coverage multiplied by 1.09.~~

~~(2) With respect to the rate charged for coverage provided in 2015 and each subsequent year, the rate charged in the prior year multiplied by a factor of one plus the percentage change in the statewide average premium for the second lowest cost silver plan offered on the Exchange. The Exchange shall determine the percentage change in the statewide average premium for the second lowest cost silver plan by subtracting subparagraph (A) from subparagraph (B) and dividing the result by subparagraph (A).~~

~~(A) The average of the premiums charged in the year prior to the applicable year for the second lowest cost silver plan in all 19 rating regions, with the premium for each region weighted based~~

1 *on the region's relative share of the Exchange's total individual*
2 *enrollment according to the latest data available to the Exchange.*

3 *(B) The average of the premiums to be charged in the applicable*
4 *year for the second lowest cost silver plan in all 19 rating regions,*
5 *with the premium for each region weighted based on the region's*
6 *relative share of the Exchange's total individual enrollment*
7 *according to the latest data available to the Exchange.*

8 *(3) The Exchange shall determine the percentage change in the*
9 *statewide average premium no later than 30 days after the*
10 *Exchange's rates for individual coverage for the applicable year*
11 *have been finalized.*

12 (b) When a federally eligible defined individual submits a
13 premium payment, based on the quoted premium charges, and that
14 payment is delivered or postmarked, whichever occurs earlier,
15 within the first 15 days of the month, coverage shall begin no later
16 than the first day of the following month. When that payment is
17 neither delivered ~~or~~ nor postmarked until after the 15th day of a
18 month, coverage shall become effective no later than the first day
19 of the second month following delivery or postmark of the
20 payment.

21 (c) During the first 30 days after the effective date of the health
22 benefit plan, the individual shall have the option of changing
23 coverage to a different health benefit plan design offered by the
24 same carrier. If the individual notified the plan of the change within
25 the first 15 days of a month, coverage under the new health benefit
26 plan shall become effective no later than the first day of the
27 following month. If an enrolled individual notified the carrier of
28 the change after the 15th day of a month, coverage under the health
29 benefit plan shall become effective no later than the first day of
30 the second month following notification.

31 (d) (1) On and after January 1, 2014, and except as provided
32 in paragraph (2), this section shall apply only to individual
33 grandfathered health plans previously issued pursuant to this
34 section to federally eligible defined individuals.

35 (2) If Section 5000A of the Internal Revenue Code, as added
36 by Section 1501 of PPACA, is repealed or amended to no longer
37 apply to the individual market, as defined in Section 2791 of the
38 federal Public Health Service Act (42 U.S.C. Section 300gg-91),
39 paragraph (1) shall become inoperative on the date of that repeal

1 or amendment and this section shall apply to health benefit plans
2 issued, amended, or renewed on or after that date.

3 (3) For purposes of this subdivision, the following definitions
4 apply:

5 (A) “Grandfathered health plan” has the same meaning as that
6 term is defined in Section 1251 of PPACA.

7 (B) “PPACA” means the federal Patient Protection and
8 Affordable Care Act (Public Law 111-148), as amended by the
9 federal Health Care and Education Reconciliation Act of 2010
10 (Public Law 111-152), and any rules, regulations, or guidance
11 *issues issued* pursuant to that law.

12 ~~SEC. 19.~~

13 *SEC. 21.* Section 10901.8 of the Insurance Code is amended
14 to read:

15 10901.8. All health benefit plans offered to a federally eligible
16 defined individual shall be renewable with respect to the individual
17 and dependents at the option of the enrolled individual except in
18 cases of:

19 (a) Nonpayment of the required premiums.

20 (b) Fraud or misrepresentation by the enrolled individual.

21 (c) The carrier ceases to provide or arrange for the provision of
22 health care services for individual health benefit plan contracts in
23 this state, provided, however, that the following conditions are
24 satisfied:

25 (1) Notice of the decision to cease new or existing individual
26 health benefit plans in this state is provided to the commissioner
27 and to the contractholder.

28 (2) Individual health benefit plan contracts subject to this chapter
29 shall not be canceled for 180 days after the date of the notice
30 required under paragraph (1) and for that business of a carrier that
31 remains in force, any carrier that ceases to offer for sale new
32 individual health benefit plan contracts shall continue to be
33 governed by this article with respect to business conducted under
34 this chapter.

35 (3) A carrier that ceases to write new individual business in this
36 state after the effective date of this chapter shall be prohibited from
37 offering for sale new individual health benefit plan contracts in
38 this state for a period of three years from the date of the notice to
39 the commissioner.

(d) When a carrier withdraws a health benefit plan design from the individual market, provided that a carrier makes available to eligible individuals all health plan benefit designs that it makes available to new individual business, and provided that premium for the new health benefit plan complies with the renewal increase requirements set forth in Section 10901.9.

(e) (1) On and after January 1, 2014, and except as provided in paragraph (2), this section shall apply only to individual grandfathered health plans previously issued pursuant to this section to federally eligible defined individuals.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Section 300gg-91), paragraph (1) shall become inoperative on the date of that repeal or amendment and this section shall apply to health benefit plans issued, amended, or renewed on or after that date.

(3) For purposes of this subdivision, the following definitions apply:

(A) "Grandfathered health plan" has the same meaning as that term is defined in Section 1251 of PPACA.

(B) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance ~~issues~~ *issued* pursuant to that law.

~~SEC. 20.~~

SEC. 22. Section 10901.9 of the Insurance Code is amended to read:

10901.9. Commencing January 1, 2001, premiums for health benefit plans offered, delivered, amended, or renewed by carriers shall be subject to the following requirements:

(a) The premium for new business for a federally eligible defined individual shall not exceed the following amounts:

(1) For health benefit plans identified in subdivision (d) of Section 10785 that offer services through a preferred provider arrangement, the average premium paid by a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual. However, for federally qualified individuals

1 who are between ~~the ages of~~ 60 to 64 *years of age*, inclusive, the
2 premium shall not exceed the average premium paid by a subscriber
3 of the Major Risk Medical Insurance Program who is 59 years of
4 age and resides in the same geographic area as the federally eligible
5 defined individual.

6 (2) For health benefit plans identified in subdivision (d) of
7 Section 10785 that do not offer services through a preferred
8 provider arrangement, 170 percent of the standard premium charged
9 to an individual who is of the same age and resides in the same
10 geographic area as the federally eligible defined individual.
11 However, for federally qualified individuals who are between ~~the~~
12 ~~ages of~~ 60 to 64 *years of age*, inclusive, the premium shall not
13 exceed 170 percent of the standard premium charged to an
14 individual who is 59 years of age and resides in the same
15 geographic area as the federally eligible defined individual.

16 (b) The premium for in force business for a federally eligible
17 defined individual shall not exceed the following amounts:

18 (1) For health benefit plans identified in subdivision (d) of
19 Section 10785 that offer services through a preferred provider
20 arrangement, the average premium paid by a subscriber of the
21 Major Risk Medical Insurance Program who is of the same age
22 and resides in the same geographic area as the federally eligible
23 defined individual. However, for federally qualified individuals
24 who are between ~~the ages of~~ 60 and 64 *years of age*, inclusive, the
25 premium shall not exceed the average premium paid by a subscriber
26 of the Major Risk Medical Insurance Program who is 59 years of
27 age and resides in the same geographic area as the federally eligible
28 defined individual.

29 (2) For health benefit plans identified in subdivision (d) of
30 Section 10785 that do not offer services through a preferred
31 provider arrangement, 170 percent of the standard premium charged
32 to an individual who is of the same age and resides in the same
33 geographic area as the federally eligible defined individual.
34 However, for federally qualified individuals who are between ~~the~~
35 ~~ages of~~ 60 and 64 *years of age*, inclusive, the premium shall not
36 exceed 170 percent of the standard premium charged to an
37 individual who is 59 years of age and resides in the same
38 geographic area as the federally eligible defined individual. The
39 premium effective on January 1, 2001, shall apply to in force
40 business at the earlier of either the time of renewal or July 1, 2001.

(c) The premium applied to a federally eligible defined individual may not increase by more than the following amounts:

(1) For health benefit plans identified in subdivision (d) of Section 10785 that offer services through a preferred provider arrangement, the average increase in the premiums charged to a subscriber of the Major Risk Medical Insurance Program who is of the same age and resides in the same geographic area as the federally eligible defined individual.

(2) For health benefit plans identified in subdivision (d) of Section 10785 that do not offer services through a preferred provider arrangement, the increase in premiums charged to a nonfederally qualified individual who is of the same age and resides in the same geographic area as the federally defined eligible individual. The premium for an eligible individual may not be modified more frequently than every 12 months.

(3) For a contract that a carrier has discontinued offering, the premium applied to the first rating period of the new contract that the federally eligible defined individual elects to purchase shall be no greater than the premium applied in the prior rating period to the discontinued contract.

~~(m)~~

(d) (1) On and after January 1, 2014, and except as provided in paragraph (2), this section shall apply only to individual grandfathered health plans previously issued pursuant to this section to federally eligible defined individuals.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Section 300gg-91), paragraph (1) shall become inoperative on the date of that repeal or amendment and this section shall apply to health benefit plans issued, amended, or renewed or amended on or after that date.

(3) For purposes of this subdivision, the following definitions apply:

(A) "Grandfathered health plan" has the same meaning as that term is defined in Section 1251 of PPACA.

(B) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010

(Public Law 111-152), and any rules, regulations, or guidance issues issued pursuant to that law.

~~SEC. 21.~~

SEC. 23. Section 10902.3 of the Insurance Code is amended to read:

10902.3. (a) At least 20 business days prior to renewing or amending a health benefit plan contract subject to this chapter, or at least 20 business days prior to the initial offering of a health benefit plan subject to this chapter, a carrier shall file a statement with the commissioner in the same manner as required for small employers as outlined in Section 10717. The statement shall include a statement certifying that the carrier is in compliance with subdivision (a) of Section 10901.3 and with Section 10901.9. Any action by the commissioner, as permitted under Section 10717, to disapprove, suspend, or postpone the plan's use of a carrier's health benefit plan design shall be in writing, specifying the reasons the health benefit plan does not comply with the requirements of this chapter.

(b) Prior to making any changes in the premium, the carrier shall file an amendment in the same manner as required for small employers as outlined in Section 10717, and shall include a statement certifying the carrier is in compliance with subdivision (a) of Section 10901.3 and with Section 10901.9. All other changes to a health benefit plan previously filed with the commissioner pursuant to subdivision (a) shall be filed as an amendment in the same manner as required for small employers as outlined in Section 10717.

(c) (1) On and after January 1, 2014, and except as provided in paragraph (2), this section shall apply only to individual grandfathered health plans previously issued pursuant to this section to federally eligible defined individuals.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Section 300gg-91), paragraph (1) shall become inoperative on the date of that repeal or amendment and this section shall apply to health benefit plans issued, amended, or renewed on or after that date.

(3) For purposes of this subdivision, the following definitions apply:

1 (A) “Grandfathered health plan” has the same meaning as that
2 term is defined in Section 1251 of PPACA.

3 (B) “PPACA” means the federal Patient Protection and
4 Affordable Care Act (Public Law 111-148), as amended by the
5 federal Health Care and Education Reconciliation Act of 2010
6 (Public Law 111-152), and any rules, regulations, or guidance
7 ~~issues~~ *issued* pursuant to that law.

8 ~~SEC. 22.~~

9 ~~SEC. 24.~~ Section 10902.6 of the Insurance Code is repealed.

10 ~~SEC. 23.~~

11 ~~SEC. 25.~~ Section 12672 of the Insurance Code is amended to
12 read:

13 12672. (a) Any group policy issued, amended, or renewed in
14 this state on or after January 1, 1983, which provides insurance
15 for employees or members on an expense-incurred or service basis,
16 other than for a specific disease or for accidental injuries only,
17 shall contain a provision that an employee or member whose
18 coverage under the group policy has been terminated for any reason
19 except as provided in this part, shall be entitled to have a converted
20 policy issued to him or her by the insurer under whose group policy
21 he or she was covered, without evidence of insurability, subject
22 to the terms and conditions of this part.

23 (b) (1) This section shall be inoperative on January 1, 2014.

24 (2) If Section 5000A of the Internal Revenue Code, as added
25 by Section 1501 of PPACA, is repealed or amended to no longer
26 apply to the individual market, as defined in Section 2791 of the
27 federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this
28 section shall become operative on the date of that repeal or
29 amendment.

30 (3) For purposes of this subdivision, “PPACA” means the federal
31 Patient Protection and Affordable Care Act (Public Law 111-148),
32 as amended by the federal Health Care and Education
33 Reconciliation Act of 2010 (Public Law 111-152), and any rules,
34 regulations, or guidance issued pursuant to that law.

35 ~~SEC. 24.~~

36 ~~SEC. 26.~~ Section 12682.1 of the Insurance Code is amended
37 to read:

38 12682.1. This section does not apply to a policy that primarily
39 or solely supplements Medicare. The commissioner may adopt
40 rules consistent with federal law to govern the discontinuance and

1 replacement of plan policies that primarily or solely supplement
2 Medicare.

3 (a) (1) Every group policy entered into, amended, or renewed
4 on or after September 1, 2003, that provides hospital, medical, or
5 surgical expense benefits for employees or members shall provide
6 that an employee or member whose coverage under the group
7 policy has been terminated by the employer shall be entitled to
8 convert to nongroup membership, without evidence of insurability,
9 subject to the terms and conditions of this section.

10 (2) If the health insurer provides coverage under an individual
11 health insurance policy, other than conversion coverage under this
12 part, it shall offer one of the two health insurance policies that the
13 insurer is required to offer to a federally eligible defined individual
14 pursuant to Section 10785. The health insurer shall provide this
15 coverage at the same rate established under Section 10901.3 for a
16 federally eligible defined individual.

17 (3) If the health insurer does not provide coverage under an
18 individual health insurance policy, it shall offer a health benefit
19 plan contract that is the same as a health benefit contract offered
20 to a federally eligible defined individual pursuant to Section
21 1366.35. The health insurer shall offer the most popular preferred
22 provider organization plan that has the greatest number of enrolled
23 individuals for its type of plan as of January 1 of the prior year, as
24 reported by plans by January 31, 2003, and annually thereafter,
25 that provide coverage under an individual health care service plan
26 contract to the department or the Department of Managed Health
27 Care. A health insurer subject to this paragraph ~~plan~~ shall provide
28 this coverage with the same cost-sharing terms and at the same
29 premium as a health care service plan providing coverage to that
30 individual under an individual health care service plan contract
31 pursuant to Section 1399.805. The health insurer shall file the
32 health benefit plan contract it will offer, including the premium it
33 will charge and the cost-sharing terms of the contract, with the
34 Department of Insurance.

35 (b) A conversion policy shall not be required to be made
36 available to an employee or insured if termination of his or her
37 coverage under the group policy occurred for any of the following
38 reasons:

39 (1) The group policy terminated or an employer's participation
40 terminated and the insurance is replaced by similar coverage under

1 another group policy within 15 days of the date of termination of
2 the group coverage or the employer's participation.

3 (2) The employee or insured failed to pay amounts due the health
4 insurer.

5 (3) The employee or insured was terminated by the health insurer
6 from the policy for good cause.

7 (4) The employee or insured knowingly furnished incorrect
8 information or otherwise improperly obtained the benefits of the
9 policy.

10 (5) The employer's hospital, medical, or surgical expense benefit
11 program is self-insured.

12 (c) A conversion policy is not required to be issued to any person
13 if any of the following facts are present:

14 (1) The person is covered by or is eligible for benefits under
15 Title XVIII of the United States Social Security Act.

16 (2) The person is covered by or is eligible for hospital, medical,
17 or surgical benefits under any arrangement of coverage for
18 individuals in a group, whether insured or self-insured.

19 (3) The person is covered for similar benefits by an individual
20 policy or contract.

21 (4) The person has not been continuously covered during the
22 three-month period immediately preceding that person's
23 termination of coverage.

24 (d) Benefits of a conversion policy shall meet the requirements
25 for benefits under this chapter.

26 (e) Unless waived in writing by the insurer, written application
27 and first premium payment for the conversion policy shall be made
28 not later than 63 days after termination from the group. A
29 conversion policy shall be issued by the insurer which shall be
30 effective on the day following the termination of coverage under
31 the group contract if the written application and the first premium
32 payment for the conversion contract are made to the insurer not
33 later than 63 days after the termination of coverage, unless these
34 requirements are waived in writing by the insurer.

35 (f) The conversion policy shall cover the employee or insured
36 and his or her dependents who were covered under the group policy
37 on the date of their termination from the group.

38 (g) A notification of the availability of the conversion coverage
39 shall be included in each evidence of coverage or other legally
40 required document explaining coverage. However, it shall be the

1 sole responsibility of the employer to notify its employees of the
2 availability, terms, and conditions of the conversion coverage
3 which responsibility shall be satisfied by notification within 15
4 days of termination of group coverage. Group coverage shall not
5 be deemed terminated until the expiration of any continuation of
6 the group coverage. For purposes of this subdivision, the employer
7 shall not be deemed the agent of the insurer for purposes of
8 notification of the availability, terms, and conditions of conversion
9 coverage.

10 (h) As used in this section, “hospital, medical, or surgical
11 benefits under state or federal law” do not include benefits under
12 Chapter 7 (commencing with Section 14000) or Chapter 8
13 (commencing with Section 14200) of Part 3 of Division 9 of the
14 Welfare and Institutions Code, or Title XIX of the United States
15 Social Security Act.

16 (i) (1) On and after January 1, 2014, and except as provided in
17 paragraph (2), this section shall not apply to any health insurance
18 policies.

19 (2) If Section 5000A of the Internal Revenue Code, as added
20 by Section 1501 of PPACA, is repealed or amended to no longer
21 apply to the individual market, as defined in Section 2791 of the
22 federal Public Health Service Act (42 U.S.C. Section 300gg-91),
23 paragraph (1) shall become inoperative on the date of that repeal
24 or amendment and this section shall apply to health insurance
25 policies issued, renewed, or amended on or after that date.

26 (3) For purposes of this subdivision, “PPACA” means the federal
27 Patient Protection and Affordable Care Act (Public Law 111-148),
28 as amended by the federal Health Care and Education
29 Reconciliation Act of 2010 (Public Law 111-152), and any rules,
30 regulations, or guidance ~~issues~~ *issued* pursuant to that law.

31 ~~SEC. 25.~~

32 *SEC. 27.* Section 12682.2 is added to the Insurance Code, to
33 read:

34 12682.2. (a) (1) At least 60 days prior to the policy renewal
35 date, an insurer that does not otherwise issue individual health
36 insurance policies shall issue the notice described in paragraph (2)
37 to any policyholder of an individual health insurance policy issued
38 pursuant to Section 12682.1 that is not a grandfathered health plan.

39 (2) The notice shall be in at least 12-point type and shall include
40 all of the following information:

1 (A) Notice that, as of the renewal date, the individual policy
2 will not be renewed.

3 (B) The availability of individual health coverage through
4 Covered California, including at least all of the following:

5 (i) That, beginning on January 1, 2014, individuals seeking
6 coverage may not be denied coverage based on health status.

7 (ii) That the premium rates for coverage offered by a health care
8 service plan or a health insurer cannot be based on an individual's
9 health status.

10 (iii) That individuals obtaining coverage through Covered
11 California may, depending upon income, be eligible for premium
12 subsidies and cost-sharing subsidies.

13 (iv) That individuals seeking coverage must obtain this coverage
14 during an open or special enrollment period, and describe the open
15 and special enrollment periods that may apply.

16 (b) (1) At least 60 days prior to the policy renewal date, an
17 insurer that issues individual health insurance policies shall issue
18 the notice described in paragraph (2) to a policyholder of an
19 individual health insurance policy issued pursuant to Section 10785
20 or 12682.1 that is not a grandfathered health plan.

21 (2) The notice shall be in at least 12-point type and shall include
22 all of the following:

23 (A) Notice that, as of the renewal date, the individual policy
24 shall not be renewed.

25 (B) Information regarding the individual health insurance policy
26 that the insurer will issue as of January 1, 2014, which the insurer
27 has reasonably concluded is the most comparable to the
28 individual's current policy. The notice shall include information
29 on premiums for the possible replacement policy and instructions
30 that the individual can continue their coverage by paying the
31 premium stated by the due date.

32 (C) Notice of the availability of other individual health coverage
33 through Covered California, including at least all of the following:

34 (i) That, beginning on January 1, 2014, individuals seeking
35 coverage may not be denied coverage based on health status.

36 (ii) That the premium rates for coverage offered by a health care
37 service plan or a health insurer cannot be based on an individual's
38 health status.

1 (iii) That individuals obtaining coverage through Covered
2 California may, depending upon income, be eligible for premium
3 subsidies and cost-sharing subsidies.

4 (iv) That individuals seeking coverage must obtain this coverage
5 during an open or special enrollment period, and describe the open
6 and special enrollment periods that may apply.

7 (c) No later than September 1, 2013, the commissioner, in
8 consultation with the Department of Managed Health Care, shall
9 adopt uniform model notices that health plans shall use to comply
10 with subdivisions (a) and (b) *and Sections 10127.16 and 10786*.
11 Use of the model notices shall not require prior approval by the
12 department. The model notices adopted for purposes of this section
13 shall not be subject to the Administrative Procedure Act (Chapter
14 3.5 (commencing with Section 11340) of Part 1 of Division 3 of
15 Title 2 of the Government Code). *The director may modify the*
16 *wording of these model notices specifically for purposes of clarity,*
17 *readability, and accuracy.*

18 (d) For purposes of this section, the following definitions shall
19 apply:

20 (1) "Covered California" means the California Health Benefit
21 Exchange established pursuant to Section 100500 of the
22 Government Code.

23 (2) "Grandfathered health plan" has the same meaning as that
24 term is defined in Section 1251 of PPACA.

25 (3) "PPACA" means the federal Patient Protection and
26 Affordable Care Act (Public Law 111-148), as amended by the
27 federal Health Care and Education Reconciliation Act of 2010
28 (Public Law 111-152), and any rules, regulations, or guidance
29 issued pursuant to that law.

30 ~~SEC. 26.~~

31 *SEC. 28.* No reimbursement is required by this act pursuant to
32 Section 6 of Article XIII B of the California Constitution because
33 the only costs that may be incurred by a local agency or school
34 district will be incurred because this act creates a new crime or
35 infraction, eliminates a crime or infraction, or changes the penalty
36 for a crime or infraction, within the meaning of Section 17556 of
37 the Government Code, or changes the definition of a crime within
38 the meaning of Section 6 of Article XIII B of the California
39 Constitution.

1 ~~SEC. 27.~~

2 *SEC. 29.* This act is an urgency statute necessary for the
3 immediate preservation of the public peace, health, or safety within
4 the meaning of Article IV of the Constitution and shall go into
5 immediate effect. The facts constituting the necessity are:

6 In order for the public to be informed in a timely manner of
7 critical changes to health care coverage, it is necessary that this
8 bill take effect immediately.

O